

# **MENTAL HEALTH AND CULTURAL DIVERSITY INTERNATIONAL CONFERENCE**

**Exploring Transformative Practices  
and Service Models**

**Leicester (UK)  
22–24 June 2016**

**CONFERENCE PROGRAMME  
AND BOOK OF ABSTRACTS**

**INTERNATIONAL CONFERENCE  
ON  
MENTAL HEALTH and CULTURAL DIVERSITY  
EXPLORING TRANSFORMATIVE PRACTICES  
AND SERVICE MODELS**

**#mhcd2016**

**22- 24 JUNE 2016**

**De Montfort University, Leicester**

**BOOK OF ABSTRACTS**

# Contents

## **Welcome Message**

Conference Programme	05
Oral Concurrent Sessions/Workshops	08
Poster Presentations	12
Conference Organising Committee	14
Keynote Speakers	16
Abstracts - Keynote Presentations	22
Abstracts - Concurrent Sessions and Workshops (22 June 2016)	31
Abstracts - Concurrent Sessions and Workshops (23 June 2016)	38
Abstracts - Poster Presentations	45
General Information	53
Our Sponsors	54

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## Conference themes

- Mental health and cultural diversity
- User and carer perspectives
- Practice and Service models
- Transformative practice
- Culturally appropriate assessments & interventions
- Ageing and dementia care
- Global mental health
- Cultural & critical psychiatry
- Spirituality and mental health
- Cultural competency and care
- Volunteering perspectives
- Family centred approaches
- Disability and mental health
- Mental health promotion

## Welcome Message

It gives me great pleasure to welcome you all to the international conference on Mental Health and Cultural Diversity: Exploring transformative Practices and Service models. Leicester is one of the most diverse cities in the UK with nearly half the population of Leicester city from diverse ethnic communities. It is estimated that approximately 450 million people worldwide experience mental ill health. 1 in 4 families worldwide is likely to have at least one member experiencing mental ill health or behavioural difficulties. We know that attitudes towards mental ill health vary among people from different cultures, ethnic background and countries. Mental ill health is stigmatised in many cultures forcing people to live in denial or preventing them from seeking help when they require it. Ethnicity and cultural beliefs affects the perception of mental ill health, help seeking and service access, and service utilisation.

The aim of the conference is to discuss and debate a range of appropriate and acceptable services for people from diverse cultural communities around the world. This conference is for medical, health and social care professionals and service providers, including psychiatrists, psychologists, nurses and social workers and educationalists. This conference is also for service commissioners, service users and carers, academics, policy makers, and voluntary sector organisations.

We have an excellent programme with international speakers from many countries which will be of value to you in your work for developing transformative practice and services. Our speakers are passionate about confronting inequalities in mental health services with reference to ethnicity and cultural diversity. I believe that this international conference will provide us all with the opportunity to develop new ideas, create an environment for exchange and enrichment and learn from diverse experiences to increase our knowledge to influence mental health policy. This will impact on developing transformative practices and service models for ALL including people from diverse ethnic and cultural communities.

I wish you all an inspiring and productive conference and stay in Leicester.

Raghu Raghavan  
***Chair of Conference organising committee***

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# Day 1

## Wednesday 22 June 2016

08:00	<b>Registration opens</b>
09. 40-10.40	<b>Inaugural ceremony and addresses</b>
Oliver Suite	<p>Welcome by Professor Raghu Raghavan</p> <p><b>Inaugural addresses:</b></p> <p><b>Professor Andy Collop</b> Deputy Vice-Chancellor, De Montfort University</p> <p><b>Dr Simon Oldroyd</b> Dean, Faculty of Health and Life Sciences</p> <p><b>Jenny Edwards</b> Chief Executive, Mental Health Foundation, London</p> <p><b>Showcase smoothie presentation / dance</b></p>
10. 40	Coffee
11.00-12.30	<b>Panel Keynotes 1: Mental Health and Cultural Diversity</b>
Oliver Suite	<p><b>Chair: Professor Surinder Sharma</b></p> <p>(KN 01) <b>Ethnic inequalities in severe mental disorders-economic, social and institutional harms</b> Professor James Nazroo (UK)</p> <p>(KN 02) <b>Culture and mental health: Developing transformative practices and service models</b> Professor Dinesh Bhugra (UK)</p> <p>(KN 03) <b>What do we mean by transformative services for diverse cultural communities</b> Professor Sarah Salway (UK)</p>
12.30-13.30	Lunch
13.30–15.00	<b>Oral presentations/symposia/workshops</b>
15.00-15.30	Coffee
15.30-17.30	<b>Panel Keynotes 2: Transforming community mental health services</b>
Oliver Suite	<p><b>Chair: Professor Lixian Jin</b></p> <p>(KN 04) <b>Community development as a transformational practice in mental health care</b> Dr Phil Thomas (UK)</p> <p>(KN 05) <b>Transforming communities for inclusion of persons with psychosocial disabilities</b> Dr Bhargavi Davar (India)</p> <p>(KN06) <b>Delivering community mental health in resource-poor settings - combining technology with volunteering</b> Dr. Manoj Kumar (India)</p> <p>(KN 07) <b>Adversity and innovation: Insights from work in war and disaster</b> Ananda Galppatti (Sri Lanka)</p>
19.00	Conference reception arts performance

## Day 2

### Thursday 23 June 2016

08:00	Registration opens
08.30-10.00	<b>Panel Keynotes 3: International perspectives</b>
Oliver Suite	<b>Chair: Dr. Mohammed Abbas</b>  (KN 08) <b>Mental health and migration research in Australia: Systemic problems and consequences</b> Professor Harry Minas (Australia)  (KN 09) <b>Cultural diversity and mental health: The Canadian experience</b> Professor Kwame Mckenzie (Canada)  (KN 10) <b>Culture and ethnicity and mental health care: An evolutionary perspective</b> Dr Riadh Abed (UK)
10.30-11.00	Coffee
11.00-12.30	<b>Panel Keynotes 4: Culture and mental health recovery</b>
Oliver Suite	<b>Chair: Dr. Fabida Noushad</b>  (KN 11) <b>Black mental health service user/survivor advocacy and activism: Yesterday, today, tomorrow</b> Dr Jayasree Kalathil (UK)  (KN 12) <b>Cultural Adaptations of Interventions</b> Dr. Shanaya Rathod (UK)  (KN 13) <b>Cultural perspectives and recovery</b> Professor Mike Slade (UK)
12.30-13.30	Lunch
13.30–15.00	<b>Oral presentations/symposia/workshops</b>
15.00-15.30	Coffee
15.30-17.30	<b>Panel Keynote 5: Global mental health</b>
Oliver Suite	<b>Chair: Professor Brian Brown</b>  (KN 14) <b>Dialogues between critical psychiatry and global mental health: critiques and commonalities</b> Professor Vikram Patel (India/UK)  (KN 15) <b>World Awareness for Children in Trauma: Towards a universal psychosocial model</b> Professor Panos Vostanis (UK)  (KN 16) <b>Ethical and sustainable services for mental health and wellbeing in non-western settings</b> Dr Suman Fernando (UK)  (KN 17) <b>Globalisation and ecological approach - between social determinants and subjectivity: the experience of Trieste</b> Professor Roberto Mezzina (Italy)
17.45-18.30	<b>Special interest group meeting (Room : Morley Lounge)</b>
19.00	Conference dinner

# Day 3

## Friday 24 June 2016

08:00	Registration opens
08.30-10.00	<b>Panel Keynotes 6: Transformative services</b>
Oliver Suite	<b>Dr. Satheesh Kumar</b>  (KN18) <b>Culturally sensitive transformative practices &amp; service models in Africa: A Nigerian perspective</b> Dr Erinfolami Adebayo Rasheed (Nigeria)  (KN19) <b>Joys and tribulations in dealing with socio-cultural diversities in mental health practice in India</b> Professor Santosh Chaturvedi (India)  (KN20) <b>Global volunteering in Mental health</b> Dr Peter Hughes (UK)
10.30-11.00	Coffee
11.00-12.30	<b>Panel keynotes 7: Aging and dementia</b>
Oliver Suite	<b>Chair: Paul Illingworth</b>  (KN21) <b>Encouraging Access to South Asians for a timely dementia diagnosis</b> Dr Naaheed Mukudam (UK)  (KN22) <b>Dementia Care for diverse cultural communities</b> Dr. Hari Subramaniam (UK)  (KN23) <b>Understanding Extreme States through the language of post psychiatry</b> Olga Runciman (Denmark)
12.30-13.15	Lunch
13.15-15.30	<b>Panel Keynotes 8: Policy and Practice</b>
Oliver Suite	<b>Chair: Professor Adrian Childs</b>  (KN 24) <b>Human Rights, mental health and human dignity</b> Dr Albert Persaud (UK)  (KN 25) <b>Imagining culturally competent mental health care</b> Professor Raghu Raghavan (UK)  (KN 26) <b>Ten years of NOT Delivering Race Equality in Mental Health in England- Where do we go from here?</b> Professor Shashi Shashidharan (UK)
15.30	Closing ceremony

# ORAL CONCURRENT SESSIONS/WORKSHOPS

22 JUNE 2016 (13.30 to 15.00)

Number	Title	Room
OP1	<p>The multilingual experience: Where is it? <i>Beverly Costa</i></p> <p>Collaborating with providers to uncover and address racial inequalities to enhance mental health service provision <i>M Konidaris and M. Petrakis</i></p>	Morley Lounge
OP2	<p>Spirituality and meditation as mediating factors in black families wellbeing <i>Bertha Ochieng</i></p> <p>Spiritus contra Spiritum: Including Spirituality in addiction treatments for recovery :a systematic review <i>Santiago de Ossorno Garcia, Javier Martin Babarro, Maria de la Paz Toldos Romero</i></p> <p>Religious identity and its influence of religious discourse in mental health <i>Karim Mitha</i></p>	Oliver Suite
OP3	<p>EDAWU: A journey from in-patient rehabilitation to a focus on community treatment and involvement <i>Nandini Chakraborty, A Lucas and A Erinfolami</i></p> <p>Leicester –Gondar project in Ethiopia <i>Lynn Wroe, Heather Dipple</i></p> <p>Learning disability collaborative projects in India <i>Satheesh Kumar</i></p>	Morley Dining Room
OP4	<p>Dementia support and understanding within the South Asian community <i>Bina Sitaram and Santanu Chakrabarti</i></p> <p>Aging well in Indonesia: Meeting the mental health needs of elderly Indonesians <i>Aliza J Hunt</i></p> <p>Working with migrant communities: Achieving cultural competency in dementia care <i>Karan Jutlla</i></p>	Committee Room 2



OP5	<p>Mental Health Disorders in Children and Adolescents with Intellectual Disabilities in Egypt <i>Ereny Gobrial</i></p> <p>The views of family caregivers on deinstitutionalization of psychiatry in Russia <i>Olga Shek</i></p> <p>The big Five Factor Model of Personality Traits and Psychological Resilience of Special Education Needs teachers in Egypt <i>Fawkeia Radwan, Ereny Gobrial</i></p>	Front Lounge
OP6	<p>Co-Producing an Innovative Therapeutic Approach to Tackling Child Sexual Exploitation: A UK Context</p> <p>Innovating on the Frontline: Developing a Novel Child Sexual Exploitation Service in a High Profile Area <i>Romana Farooq, Tania Rodrigues &amp; Naomi Hickey</i></p> <p>Missing Voices: Minoritised Communities &amp; Child Sexual Exploitation <i>Romana Farooq, Tania Rodrigues &amp; Naomi Hickey</i></p> <p>Co-Developing Youth Participation in Risk-Averse and Chaotic Systems: Challenges &amp; opportunities <i>Romana Farooq, Tania Rodrigues &amp; Naomi Hickey</i></p>	Holmes Lounge
<b>Workshop</b> WS1	<p>Cultural competence in Practice: Are you compliant? <i>Tiwalola Kolapo</i></p>	Committee Room 4
WS2	<p>Mental Health Issues among the Black and Minority Ethnic (BAME) and men who have sex with men (MSM) <i>Mehboob Dada</i></p>	Committee Room 3

# ORAL CONCURRENT SESSIONS/WORKSHOPS

23 JUNE 2016 (13.30 to 15.00)

Number	Title	Room
OP7	Suicide first aid guidelines for people of immigrant and refugee backgrounds <i>Erminia Colucci and Harry Minas</i>	Committee Room 1
	Ethnicity, immigration and schizophrenia: an evolutionary link <i>Mohammed Abbas</i>	
	Finding our way: stories of recovery from people with lived experience of mental health issues from migrant and refugee backgrounds <i>Erminia Colucci, Harry Minas &amp; Susan McDonough</i>	
OP8	Conceptions of Mental Health Within the Punjabi Sikh Diaspora Community in Ottawa, Ontario <i>Nishi Singh, Olive Wahoush, Ameil Joseph</i>	Committee Room 3
	Risk factors in the integration of migrant youth in Western countries <i>Lena Robinson</i>	
	Psychological implications of British Pakistani Muslim MSM <i>Karim Mitha</i>	
OP9	Exposure to war trauma and mental health problems among Syrian refugee children in Turkey <i>Seyda Eruyar and Panos Vostanis</i>	Oliver Suite
	Stigma, mental health and child-centred services: research with vulnerable group <i>Michelle O'Reilly</i>	
	Barriers for unaccompanied refugee minors in accessing mental health care: is it the therapy or the therapist? <i>Pallab Majumder, Michelle O'Reilly and Panos Vostanis</i>	
OP10	Making a change: co-creating culturally sensitive mental health services for the future, the story so far <i>J Glashen, D Belfon, S Wright and S.Palmer Hill</i>	Morley Dining Room
	The OREMI model: delivering an African and Caribbean centred recovery day service in west London <i>Malcolm Phillips</i>	
	Towards a Diversified Evidence Base for Global Mental Health: Cultural Adaptation of Community Mental Health Interventions in Pune, India	

	<i>Sumeet Jain</i>	
OP11	<p>Raising awareness about vascular dementia in the African-Caribbean community in the London <i>David Truswell</i></p> <p>Engaging BME Communities in Psychological Therapies through Community Development <i>Jessie Emilion</i></p> <p>Cross cultural diversity and testing memory functions <i>Eef Hogervorst</i></p>	Morley Lounge
<b>Workshop</b> WS 3	<p>Psychiatry, racism and human rights; the limitations of the western illness model <i>Suman Fernando and Jayasree Kalathil and Phil Thomas</i></p>	Front Lounge
WS 4	<p>Peer-supported Open Dialogue (POD) and the related new Dialogue First service <i>Tom Stockmann</i></p>	Committee Room 2

## POSTER PRESENTATIONS

Number	Title
POS1	<p>Establishing a mental health and psychosocial support (MHPSSmhpss) service within a medical hospital in Sierra Leone following Ebola disease outbreak</p> <p><i>Stania Kamara, Anna Walder, Antoinet Kaddedijk, Jennifer Duncan, Peter Hughes, Andrew Muana</i></p>
POS2	<p>Exploring barriers to help seeking for eating disorders among south Asian people in Leicester: a qualitative study</p> <p><i>Jackie Wales, Nicola Brewin, Raghu Raghavan, Jon Arcelus</i></p>
POS3	<p>Assessment and management of needs of children of people with young onset dementia within Younger Persons Memory Service</p> <p><i>Zena Harvey, Elizabeth Yong, Latha Velayudhan</i></p>
POS4	<p>Experiential Learning from Developing a Positive Support Short Message Service (SMS) for Improved Mental Health at the Community Level</p> <p><i>A Pasha, Z Hasnain, T Qazi, O Qureshi and A Khan</i></p>
POS5	<p>The Milestone study: Improving transition from child to adult mental health services in Europe</p> <p><i>Helena Tuomainen, Swaran Singh S, and the MILESTONE consortium</i></p>
POS6	<p>Community, Identity &amp; Mental Health: Lessons from Basic Needs Interventions in Ghana &amp; Karnataka, India.</p> <p><i>Nathan Harris</i></p>
POS7	<p>Faith-based care: Perspectives of Muslim religious leaders/imams and clinicians</p> <p><i>Karim Mithra</i></p>
POS8	<p>Antenatal depression and anxiety in pregnant women, Karachi, Pakistan</p> <p><i>A Pasha, O. Qureshi, S Saleem, A Khan</i></p>
POS9	<p>Experiential learning from the development and roll-out of a mhealth application for mental health</p>

	<i>Z Hasnain, A Pasha, O Qureshi, and A Khan</i>
POS10	<p>Exploratory RCT of a group – psychological intervention for Postnatal Depression in British Mother's of South Asian Origin – Post intervention Qualitative Study</p> <p><i>Yumna Masood, Karina Lovell, Farah Lunat, Najia Atif, Waquas Waheed, Atif Rahman, Rahena Mossabir, Nasim Chaudhry and Nusrat Husain</i></p>
POS11	<p>Exploratory RCT of a group – psychological Intervention for Postnatal Depression in British Mothers of South Asian Origin – ROSHNI-D</p> <p><i>Nusrat Husain, Karina Lovell, Farah Lunat, Najia Atif, Asad Bhokari, Issak Bhojani, Barbara Tomenson, Waquas Waheed, Atif Rahman. Nasim Chaudhry</i></p>
POS12	<p>Multi Centre RCT of a group – Psychological intervention for Perinatal depression in British mothers of south Asian Origin – ROSHNI-2 (The word Roshni means 'light' in Urdu/Hindi) – Study protocol</p> <p><i>Nusrat Husain, Karina Lovell, Farah Lunat, Chris Williams, Carolyn Chew-Graham, Penny Bee, Waquas Waheed, Najia Atif, Nasim Chaudhry, Atif Rahman, Najma Siddiqi, Jill Morrison, Joe Kai, Terry Brugh, Shanaya Rathod, Chris Roberts, Ilyas Mirza, Kamaldeep Bhui, Clare Baguley, Linda Davies, Isaak Bhojani, Peter Bower, Richard Morriss</i></p>
POS13	<p>Beliefs, attitudes and perceptions of Schizophrenia amongst the South Asian population: A review of Evidence</p> <p><i>Raghavan R; Griffin E, De Montfort University; Noushad F, Sriram V, Leicester Partnership NHS Trust, Leicester, UK</i></p>
POS14	<p>Understanding the Peer Perspective: Challenges and Motivating Factors in a Peer Delivered Intervention for Maternal Depression</p> <p><i>J.Dasgupta, P Rath, A Lazarus, R Shidhaye</i> Public Health Foundation of India, India; Sangath, India.</p>
POS15	<p>Multilingualism in inpatient mental health care in Germany</p> <p><i>Mike Mösko, Milka Jakovljevic, Antonia Diederichs, Oriana Handtke, Demet Dingoyan, Holger Schulz</i></p>
POS16	<p>Non-Asian Referrals to an Eating Disorders Service in Leicester, UK</p> <p><i>S Abbas, S Damani, L Malik, E Button, S Aldridge, R L Palmer</i></p>
POS17	<p>Investigating Mental illness in a Diverse LGB Population: Lived Experiences of the South Asian LGB Community</p> <p><i>Zaqia Rehman, Rusi Jaspal, Julie Fish, De Montfort University</i></p>

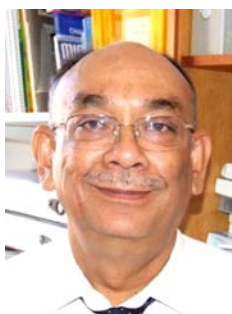
## Conference Organising Committee

### Professor Raghu Raghavan



Raghu Raghavan is Professor of Mental Health at De Montfort University Leicester and Director of the Mary Seacole Research Centre. He has been active in teaching, research and service development for people with intellectual disabilities and mental health needs. His research is encapsulated by four overarching, but inter-related themes which address important issues in disability, mental health and wellbeing: improving access to services/interventions, user involvement, practice and service development, cultural diversity and inclusion. He has strong interest in confronting mental health inequalities for people from diverse ethnic and cultural communities through transformative practices. He also works with Mental Health Action Trust (MHAT), a mental health community service in South India.

### Professor Sabyasachi Bhaumik



Sab Bhaumik is currently Honorary Chair of University of Leicester, Consultant Psychiatrist, Senior Medical Advisor and ex-Medical Director of Leicestershire Partnership NHS Trust. He is also the current Chair of the Diaspora Organisations Committee of the Royal College of Psychiatrists. He was the former Chair of the Faculty of Psychiatry of Learning Disability and was the Chair of Trent Division of the Royal College of Psychiatrists. Prof Bhaumik was awarded an OBE for services to Medicine in 2006 and was the winner of the Hospital Doctor Award in 2005. He led the next stage review programme for Learning Disability in East Midlands and is the Chair of the Working Group on Development of Care Pathways. He has published extensively in health service research and is currently leading on a research project on implementation of care pathways. He was the clinical lead for commissioning project board locally and also co-chaired the payment by results project board in mental health. He was the Chair of the British Indian Psychiatric Association from 2012 to 2014.

### Dr. Satheesh Kumar



Satheesh Kumar has been a consultant in Psychiatry of Intellectual Disability since 2002 and is currently the Medical Director of Leicestershire Partnership NHS Trust. Satheesh has a strong interest in the cultural aspect of health. He led the development of the Royal College of Psychiatrists guidance on improving access to people with Intellectual Disabilities from ethnic minority communities. He was also involved in the development of national guidance for dementia in people with Intellectual Disability. His research interests include; Intellectual disability and ageing, care pathways and service models. He is active in mental health gap training in Intellectual disability in India and is the founder of a web site providing information on autism with focus on services for people with autism in India ([www.a4autismb4bangalore.com](http://www.a4autismb4bangalore.com))

### Dr. Fabida Noushad



Fabida Noushad is a consultant psychiatrist in general adult psychiatry and Clinical Director for adult community mental health services at Leicestershire Partnership Trust. Her interests include improving quality of life for patients with severe mental illness, promoting access to health, promoting wellbeing and recovery and reducing mental health inequalities. Fabida is the 'Delivering race equality' representative for the Division of Psychiatry at Leicester Partnership Trust. She has worked on a number of initiatives to promote mental health awareness and dispel the myths about mental illnesses in the Black and Minority Ethnic community.

### Dr. Mohammed Abbas



Mo Abbas is a Consultant Psychiatrist at Leicestershire Partnership Trust and Honorary Senior Lecturer at the University of Leicester. He is a previous Chair of Iraq Subcommittee of the Royal College of Psychiatrists (RCPsych) and has been involved in a number of projects aimed at improving mental health services in Iraq as well as improving the standards of undergraduate and postgraduate medical education. He won the RCPsych award, the Psychiatric Volunteer of the Year (2015) for that work. His research interests include meanings/motives of the suicidal behaviour, evolutionary approach to schizophrenia and case formulation psychiatry.

## Conference

For all information about the conference and registration please contact:

**Tom Moore**      Tel: +44 (0)116 2506122 - Email: [tmoore@dmu.ac.uk](mailto:tmoore@dmu.ac.uk)

## Keynote Speakers

### Ananda Galappatti (Sri Lanka)

***Adversity and innovation: Insights from work in war and disaster***



Ananda is a medical anthropologist. He initiated The Good Practice Group (GPG) and an online Mental Health and Psychosocial Support Services (MHPSS) Network to incubate, harness and direct innovative practices and strategic interventions for the mental health and psychosocial support sector. His programs encourage civic engagement in order to promote empathetic and effective psychosocial services to survivors of war, natural disaster, and adversity in Sri Lanka and globally. Both GPG and MHPSS Network are based on the idea that collaboration and solidarity among ethical and creative individuals can significantly shape or influence social and institutional realities in ways that improve people's lives.

### Dr Albert Persaud (UK)

***Human Rights, Mental Health and Human Dignity***



Albert completed a successful and distinguished career in the National Health Service (NHS) and at the Department of Health (DH). He has worked in various clinical settings, research and policy development in Mental Health and Public Health for nearly 40 years. He is co-founder and currently Director at The Centre for Applied Research and Evaluation International Foundation ([www.careif.org](http://www.careif.org)) a charity based at the Centre for Psychiatry, St. Barts and The London School of Medicine & Dentistry, London, England. He has co-authored and co-edited the Mental Health Legislation Resource; an introductory compendium of some of the most commonly used English legislation in mental health for legally sound decision-making with safe, effective practice.

### Dr Bhargavi Davar (India)

***Transforming communities for inclusion of persons with psychosocial disabilities – sharing research***



Bhargavi Davar is a noted mental health activist in India. She started the Bapu Trust in Pona, India, a first national-level organisation in India entirely devoted to challenging the values, principles, and practices of the Indian mental health system. Drawing on years of work as an academic researcher, she operates on the conviction that medical interventions to manage the mentally ill have excluded attempts to address the social and structural causes of disease, and have resulted in a failed, paternalistic model of care. Bhargavi has for a number of years been at the forefront of initiatives to confront and address the problems of her country's mental health system. The Bapu Trust works with judges, government officers, and citizen groups to establish laws and regulations that protect the basic rights of people who suffer from mental illness.

### Professor Dinesh Bhugra (UK)

***Culture and Mental Health: Developing transformative practices and service models***



Dinesh Bhugra CBE is a professor of mental health and diversity at the Institute of Psychiatry at King's College London. He is an honorary consultant psychiatrist at the South London and Maudsley NHS Foundation Trust and is former president of the Royal College of Psychiatrists. He became chair of the Mental Health Foundation in 2011, and was awarded his CBE in the 2012 New Year Honours for services to psychiatry following three years as the president of the Royal College of Psychiatrists. He is president of the World Psychiatric Association (WPA). His research interests include cross-cultural psychiatry, migrant mental health, professionalism in psychiatry, depression, psychosexual medicine, service provision and decision-making.



**Dr Erinfolami Adebayo Rasheed (Nigeria)**

**Culturally sensitive transformative practices & service models in Africa: A Nigerian perspective**



Erinfolami Rasheed is Psychiatrist and Senior Lecturer at the College of Medicine, University of Lagos, Nigeria. He has been actively involved in clinical service, research and teaching in general adult psychiatry and addiction services for school children. His research and publications include acute mental health services and cultural perspectives of mental ill health in the African context.

**Professor Harry Minas (Australia)**

**Mental health and migration research in Australia: Systemic problems and consequences**



Harry Minas is Head of Global and Cultural Mental Health Unit, Centre for Mental Health, Melbourne School of Population Health, and University of Melbourne. He is the Director, Melbourne Refugee Studies Program and Co-Director, WHO Collaborating Centre for Mental Health Research and Training. He has been active in research, teaching and service development in transcultural mental health, international mental health systems development, and human rights and mental health. He has been a consultant to Australian Commonwealth and State Departments of Health, successive Australian Ministers for Immigration and Citizenship, the International Organisation for Migration, and the World Health Organisation. He is currently advisor to the ASEAN Mental Health Taskforce, Ministries of Health and Ministries of Social Affairs in Indonesia and Vietnam.

**Dr Jayasree Kalathil (UK)**

**Black mental health service user/survivor advocacy and activism: Yesterday, today, tomorrow**



Jayasree Kalathil is a researcher and survivor activist and runs the virtual collective, Survivor Research ([www.survivor-research.com](http://www.survivor-research.com)). She is also a consultant for the National Survivor User Network (NSUN). For over 18 years, she has worked to link activism and experiential knowledge to academia and knowledge production, mobilising community participation to influence policy and practice. Her research focuses on issues of racialisation, gender and human rights in mental health, and has several publications in these areas, including *Dancing to our own tunes* (2008), *Recovery and resilience* (2011) and the co-authored book *Values and ethics in mental health* (2015). She is currently co-editing a special issue of the journal *Philosophy, Psychiatry & Psychology* on the theme “mental health user/survivor research and co-production”.

**Professor James Nazroo (UK)**

**Ethnic inequalities in severe mental disorders: economic, social and institutional harms**



James Nazroo is Professor of Sociology at the University of Manchester. Issues of inequality, social justice and underlying processes of stratification have been the primary focus of his research activities, which have centred on gender, ethnicity, ageing, and the intersections between these. His work on social and health inequalities in aging populations is particularly focussed on the ‘transmission’ of inequalities across the life course, patterns of ‘retirement’, and formal and informal social and civic participation. He is co-leading the English Longitudinal Study of Aging, a multi-disciplinary panel study of those aged 50 and over.

### **Professor Kwame McKenzie (Canada)**

#### ***Cultural diversity and mental health: The Canadian experience***



Kwame McKenzie is Medical Director of Underserved Populations at the Centre for Addiction and Mental Health (CAMH), Toronto, Canada. As a Senior Scientist, he specialises in Systems and Health Equity Research at CAMH. Additionally, Dr. McKenzie is Director of the Social Aetiology of Mental Illness (SAMI) CIHR Training Program. He is a full Professor and the Co-Director of the Division of Equity Gender and Population in the Department of Psychiatry, University of Toronto. Dr. McKenzie is also CEO of the Wellesley Institute and a member of the Mental Health and Addictions Advisory Council to the Minister of Health. He sits on the Board of the United Way Toronto and the Ontario Hospitals Association.

### **Professor Mike Slade (UK)**

#### ***Cultural perspectives and mental health recovery***



Mike Slade is Professor of Mental Health Recovery and Social Inclusion, Faculty of Medicine & Health Sciences at the University of Nottingham. He has pioneered research in recovery which includes recovery and outcome focused mental health services and service user involvement, which has been highly influential. He has also made a key contribution to research on needs assessments and residential alternatives to inpatient services, and developing measures. He has written over 250 academic articles and nine books and his free booklets include Making Recovery a Reality (2008), 100 Ways to Support Recovery (2013) and REFOCUS: Promoting recovery in community mental health services (2014).

### **Dr. Manoj Kumar (India)**

#### ***Delivering community mental health in resource-poor settings - combining technology with volunteering***



Manoj Kumar is the Clinical Director of The Mental Health Action Trust ([www.mhatkerala.org](http://www.mhatkerala.org)) a not-for-profit Charitable Trust based in Calicut, Kerala. MHAT aims to demonstrate that comprehensive psychosocial care can be provided in resource-scarce settings by linking up with local partners in training volunteers and others in mental health care. This model is currently being tested in a series of projects in 4 Northern districts of Kerala. MHAT provides long term care for more than 2500 economically backward patients in the community through 37 centres, developing in the process a unique model of delivery of comprehensive community psychiatric care. Manoj also serves as a Consultant in Psycho-oncology and Community Psychiatry at the Institute of Palliative Medicine in Calicut, Kerala, India.

### **Dr. Naaheed Mukudam (UK)**

#### ***Encouraging Access to South Asians to a timely dementia diagnosis***



Naheed Mukudam is a National Institute of Health Research (NIHR) Doctoral Research Training Fellow at University College London. Her research interest is in pathways to dementia diagnosis among minority ethnic groups in the UK. People from Black and Minority Ethnic backgrounds tend to delay help-seeking for dementia until relatively late in the illness and help-seeking is often prompted by a crisis. She received NIHR Fellowship to design and test an educational intervention to encourage South Asian people in the UK to seek help earlier for dementia. Naaheed is currently carrying out a pilot randomised controlled trial of this intervention.

### **Olga Runciman (Denmark)**

#### ***Understanding Extreme States through the Language of Post-psychiatry***



Olga Runciman is a psychologist with her own practice specialising in working with youth and adults typically described as psychotic. She sees the hearing voices movement as post-psychiatric, working towards the recognition of human rights while offering hope, empowerment and access to making sense of one's experiences on an individual level. She has worked extensively with trauma and abuse, voice hearing and other sensory experiences, as well as healing and recovery. She is a board member of the Danish Psychosocial Rehabilitation network and Intervoice the international Hearing voices network. She is chair and co-founder of the Danish Hearing Voices network.

### **Dr. Peter Hughes (UK)**

#### ***Global volunteering in mental health***



Peter Hughes, is a consultant psychiatrist based at Springfield University Hospital, London. He has an interest in international psychiatry and has been travelling to Africa over the last five years doing short-term assignments in mental health. He has been involved over many years in international mental health and particularly in Primary care low resource settings.

### **Dr Phil Thomas (UK)**

#### ***Community development as a transformational practice in mental health care***



Phil Thomas left the National Health Service after working as a full-time consultant psychiatrist for over twenty years. He has worked closely with survivors of psychiatry, service users and community groups, nationally and internationally. Until recently he was chair of Sharing Voices Bradford, a community development project working with Black and Minority Ethnic communities. In his first consultant post in Manchester he worked closely with the African-Caribbean community in the city, and was part of a team that set up the Manchester African-Caribbean Mental Health Project. He has published widely and works in alliance with survivors of psychiatry, service users and community groups, nationally and internationally.

### **Professor Panos Vostanis (UK)**

#### ***World Awareness for Children in Trauma: Towards a universal psychosocial model.***



Panos Vostanis is Professor of Child Psychiatry at the University of Leicester and Visiting Professor at University College London. Panos has completed research on the assessment of mental health needs, evaluation of treatment and services for traumatized children, including those living in war zones. He is currently involved in several projects with NGOs and child trauma centres in Asia, Africa and South America as part of the World Awareness for Children in Trauma programme ([www.wacit.org](http://www.wacit.org)). He has longstanding clinical experience with vulnerable children, young people and families, i.e. in care, homeless, adopted, refugees, and young offenders.

### **Professor Roberto Mezzina (Italy)**

#### ***Globalisation and ecological approach: between social determinants and subjectivity – the experience in Trieste***



Roberto Mezzina is a psychiatrist who has contributed for the last 35 years to the experience begun by Franco Basaglia in Trieste (who inspired the Italian Mental Health Reform Law in 1978), with the deinstitutionalisation of the local psychiatric hospital and the subsequent development of alternative Community Services. For about two decades he led a comprehensive, 24-hour Community Mental Health Centre. He is Head of the WHO Collaborating Centre for Research and Training, Department of Mental Health, Trieste from 2009. He promoted the International Mental Health Collaborating Network (he is currently Vice-President). His professional experience and scientific production includes deinstitutionalisation, organisation of community services, crisis intervention, integrated approach to the therapy of psychosis, community care, rehabilitation and user involvement.

### **Dr Riadh Abed (UK)**

#### ***Culture and Ethnicity in Evolutionary Perspective.***



Riadh Abed worked as a Consultant Adult Psychiatrist in Rotherham and Hon Senior Clinical Lecturer, University of Sheffield in 1987-2012 and as Medical Director of Rotherham Doncaster and South Humber NHS Foundation Trust. He has an interest in the implications of evolutionary science for psychiatry and has published novel evolutionary theories on eating disorders, OCD and schizophrenia. Since 2013 has been Secretary of the Section of Evolutionary Psychiatry at the World Psychiatric Association and from January 2016 Chair of the Evolutionary Psychiatry Special Interest Group at the Royal College of Psychiatrists.

### **Dr Shanaya Rathod (UK)**

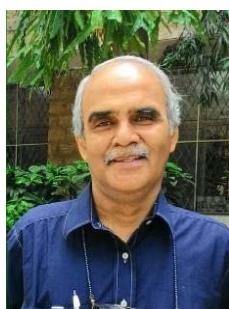
#### ***Cultural adaptations of interventions: possibilities and challenges***



Shanaya Rathod is a Consultant Psychiatrist, Clinical Service Director and Director of Research at Southern Health NHS Foundation Trust. She is involved in a range of activities in the NHS including research, audits, teaching, service and strategy development. Following her postgraduate medical education, she has completed a Doctorate in medicine, Certificate course in managing health services with the Institute of health care management and acquired a Certificate of Advance Medical leader with the British Association of Medical managers. She was a Fellow with the National Institute of Health and Care Excellence.

### **Professor Santosh Chaturvedi (India)**

#### ***Joys and tribulations in dealing with sociocultural diversities in mental health practice in India***



Santosh K Chaturvedi is the Dean, Behavioural Sciences, Professor of Psychiatry and Head of the Department of Mental Health Education, at the National Institute of Mental Health & Neurosciences, Bangalore, India. He has received the Indian Council of Medical Research award on three occasions and Indian Psychiatric Society Awards on several occasions. He is Editor in Chief, Journal of Psychosocial Rehabilitation and Mental Health. His research interests include cultural aspects of psychiatric disorders, somatisation, culture bound syndromes, and cultural adaptation of psychiatric measures.



### **Professor Sarah Salway (UK)**

***What do we mean by transformative services for diverse cultural communities?***



Sarah Salway is Professor of Public Health at the School for Health and Related Research, University of Sheffield. She leads the Health Equity and Inclusion research theme within the Section of Public Health and is also involved in the NIHR School for Public Health Research. She spent her early career living and researching in India and Bangladesh. More recently, her research has examined health and healthcare inequalities in the UK with a particular focus on minority ethnic population.

### **Professor Shashi Shashidharan (UK)**

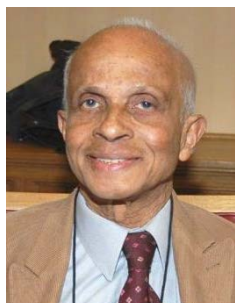
***Ten years of NOT Delivering Race Equality in Mental Health in England: Where do we go from here?***



Shashi Sashidharan is a Consultant Psychiatrist in independent practice. He is a Director of Mental Health Rights a third sector, charitable organisation, based in Glasgow, Scotland. He is a Board Member of Mental Welfare Commission for Scotland. His academic background is in psychiatric epidemiology and community mental health. He has been involved in research, service reform and campaigns to improve community mental health services and reduce and eliminate ethnic inequalities in mental health services. He has worked as a mental health consultant to the World Health Organization and the Asian Development Bank and continues to be involved in mental health reform in low and middle income countries.

### **Dr Suman Fernando (UK)**

***Ethical and sustainable services for mental health and wellbeing in non-western settings***



Suman Fernando was a consultant psychiatrist (now retired) in the British National Health Service for over twenty years until the mid-1990s. Since then he has been an academic, a writer and an advisor on mental health practice and service provision. He was also a member of the Mental Health Act Commission (a government inspectorate) for several years until 1995 where he chaired its National Standing Committee on Race and Culture. He is involved in voluntary organisations (NGOs) providing mental health services for people from minority ethnic ('racialised') groups in the UK and also for people in Sri Lanka.

### **Professor Vikram Patel (UK/INDIA)**

***Imagining mental health care: lessons from global mental health care***



Vikram Patel is psychiatrist and researcher best known for his work on child development and mental disability in low-resource settings. He is the Co-Founder and former Director of the Centre for Global Mental Health at the London School of Hygiene and Tropical Medicine (LSHTM), Co-Director of the Centre for Control of Chronic Conditions at the Public Health Foundation of India, and the Co-Founder of Sangath, an Indian NGO dedicated to research in the areas of child development, adolescent health, and mental health. In April 2015, he was listed as one of the world's 100 most influential people by TIME magazine. The main focus of his research has been on epidemiology and the sociocultural determinants and treatment of mental disorders in impoverished regions of India and other resource poor settings.

# ABSTRACTS

## KEYNOTE PRESENTATIONS

### **KN 01 Ethnic inequalities in severe mental disorders: Economic, social and institutional harms**

**Professor James Nazroo, University of Manchester UK**

In the UK ethnic minority people are more likely to be diagnosed as having a severe – psychosis related – mental illness than the white majority, and this is particularly the case for those with Black Caribbean or Black African origins. The findings for Black Caribbean people, and particularly Black Caribbean men, have been reported consistently for almost 50 years and appear to be persistent over time and across generations. And the findings also include an even greater representation at the severe end of the diagnostic spectrum, as reflected in rates of compulsory treatment. However, these findings are not fully reflected in population surveys, where the prevalence of severe mental illness among Black Caribbean people is estimated to be of the order of 2-3 times higher than that for the white majority population – still a very high rate in comparison with ethnic differences in other health outcomes, but considerably lower than the rates of diagnosis and compulsory treatment. In this paper I will set out and critically examine evidence on ethnic inequalities in severe mental illness. In doing so, I will draw comparisons with findings for other health outcomes, including common mental disorders. I will then go on to examine possible explanations for ethnic inequalities in severe mental disorder, arguing that to achieve an adequate understanding of these inequalities we need to understand the ways in which structural racism, institutional racism and interpersonal racism operate, and the impacts they have on the lives of ethnic minority people. My focus on structural and institutional racism will be primarily concerned with understanding drivers of the increased risk of illness among ethnic minority people. However, I will place particular emphasis on the role of institutional racism in order to move towards an understanding of the extraordinarily high rates of diagnosis, hospitalisation and compulsory treatment for a severe mental illness among ethnic minority people. In doing so, I will move beyond common definitions of institutional racism and go on to examine how the operation of institutions relates to both structural and interpersonal racism, how this is reflected in the procedures, cultures and collective emotions operating in institutions, and how different types of institutions operate in mutually dependent ways.

### **KN 02 Cultural Congruity and Migration**

**Professor Dinesh Bhugra CBE, Institute of Psychiatry, London UK**

There have been a number of studies from different parts of the world proving that rates of psychiatric disorders are higher in new populations. The reasons for this discrepancy are many and vary from stress of migration, vulnerability, socio-economic discrimination, cultural conflict, cultural bereavement and culture shock. Some studies have argued that rates are related to ethnic density effect though evidence for this is varied. Cultures have five dimensions socio-centrism/egocentrism; distance to power; long-term orientation; masculine/feminine cultures and how cultures avoid uncertainty. Although these dimensions are derived from cultures of large companies they carry a significant meaning. Thus if a socio-centric individual from a socio-centric culture migrates to an ego-centric society they may face problems in adjusting if others from their own culture are not around and the reverse is also true. They may face difficulties in adjustment and acculturation and also culture conflict. On top of going through cultural bereavement this may create further problems and isolation. Clinicians and policymakers have to take these dimensions into account while addressing the issues of migrant mental health. Furthermore, cultures play a major role in precipitating and perpetuating mental illnesses of different kinds and also influence help-seeking. Cultural congruity means having people from the same cultures and similar orientation and cultural dimensions being around the vulnerable individuals.

### **KN 03 Transforming health services for multi-ethnic populations: what is the role of research evidence?**

**Professor Sarah Salway, University of Sheffield UK**

The expectation that healthcare policy and practice should be informed by the best available research evidence in order to enhance quality and efficiency is now well established across most health systems. Among the various economic and demographic factors motivating “evidence-based health system transformation”, increasing ethno-cultural diversity of the population stands out as a particular challenge in the UK and elsewhere. Persistent ethnic inequalities in healthcare experiences and outcomes, as well as concerns regarding inappropriate and inefficient use of resources, have prompted a significant growth in research into ethnicity, health and healthcare in recent years. However, while the volume of such research expands, the impact on policy and practice is less readily apparent. At the same time, there are pockets of service

innovation that arise without any obvious link to formal research. This situation raises the troubling question: What is the role of research evidence? And, by implication: What is the role of researchers?

#### **KN04 Community development as a transformational practice in mental health care**

***Dr. Philip Thomas UK***

Racism in its different guises is deeply ingrained in British society, and as a significant feature of that society psychiatry and mental health services discriminate against black people in a variety of ways. For example black people are much more likely to be diagnosed with schizophrenia. In addition, the values of non-European groups, such as the importance of spirituality, family and community relationships in recovering from distress are systematically ignored within mental health services. Consequently people from black communities feel that they are treated like second class citizens by these services, and see them as punitive and coercive. In an attempt to tackle mental health inequalities affecting black people, the British Government introduced a 5 year strategy and policy, Delivering Race Equality (DRE), based in a model of community engagement. There has been disagreement about the effectiveness of this intervention. Evaluations undertaken by those close to the implementation of the policy see it largely in successful terms. However, this view is not shared by black service users, community groups and workers, and six years after the programme ended there is little evidence that DRE led to substantial or lasting improvement in the experiences of black people in mental health services. In this talk I will argue that the model of community engagement espoused by DRE conformed to what in community development circles is regarded as a 'consensus' model of community development. This is contrasted with two other models, the 'liberal', and the 'radical'. The 'consensus' model is by its nature one that mental health commissioners and practitioners feel more comfortable with, because it doesn't tackle the power differentials that exist between professional services on the one hand, and service users and communities on the other. This 'consensus' model is contrasted with the work of Sharing Voices Bradford, a community development project set up six years before DRE commenced, and which relied on a 'radical' model of community development. I will describe this model, and end by drawing attention to its strengths and limitations, especially the difficulty in sustaining a radical alternative in a project that relies on mainstream health funding for its work.

#### **KN 05 Transforming communities for inclusion of persons with psychosocial disabilities**

***Dr Bhargavi Davar, The Bapu Trust, Pona, India***

My talk will focus on the Bapu Trust experiences of 'social innovations', and how the experiential perspective as well as the CRPD framework, other than a variety of psychosocial and Arts Based Therapy skills, blended together into a smoothie of sorts, resulting in our present grandly titled program, 'Community based mental health and inclusion services'. Our frame changed for us when, instead of asking the question, 'How to treat mental illness?'. We started asking the question, 'How to facilitate the inclusion of persons with psychosocial disabilities?' Seher is a 10 year old project which became an innovation, in our own view, about 5 years ago. We engaged in research and field inquiry iteratively to tweak many parts of our services, working up our principles of practice, based on the CRPD. My presentation will introduce those aspects of the CRPD which have inspired us and gave us an aspiration to innovate. Initially, the paper will also introduce the basic design of our community project. The project is infiltrated with concepts some of which are extant (e.g. 'Social capital') and some, home grown ('Circle of care'). Then, I will go through some elements and illustrations of our iterative practice, the challenges we met, and the changes we made. Sometimes a single person who we could not help has led to a whole batch of new practices (e.g. Empathy module; 8 point framework). Sometimes a quirky action which we took had a desired result for our client, and that changed the program (e.g. 'Community confrontation'). But more often, being on the search for 'new ideas' and taking the risk to apply them in practice has been the mainstay of our social innovation, and I illustrate that with our experiments with 'Therapeutic Groups'. My paper will consider the cost implications of innovations in mental health, whether community mental health will really need a million dollars per program; or just prudent spending of monies already with governments. I will conclude with some research questions for up scaling innovation.

#### **KN 06 Delivering community mental health in resource-poor settings - combining technology with volunteering**

***Dr Manoj Kumar, Mental Health Action Trust (MHAT), Kerala, India***

In times of diminishing healthcare spending, the search for new models of mental healthcare delivery assumes added importance. The gap between ever increasing healthcare needs and available resources is starker in developing economies. In India, the problems in mental healthcare delivery in the public sector are well

documented – meager funding, lack of trained professionals and services concentrated in urban centres. The vast majority of the population lives in rural areas and cannot afford urban, private sector care. In addition, issues of quality are unaddressed despite widespread unhappiness with the predominant biomedical model of psychiatric care. Provision of rehabilitation and recovery focused care is non-existent. This presentation describes how these formidable challenges can be overcome and free, comprehensive, good quality service can be provided to the rural poor in the voluntary sector in India. Central to the MHAT model are the concepts of decentralisation, task sharing and innovative use of technology. Quality is assured through paying attention to aspects of diagnosis and management including judicious procuring of medications. The average expense on medications is as low as INR 7000 (GBP 70) per person per year! Non-professional volunteers are trained and supervised to increasingly take over tasks done by non-medical mental health professionals. This includes community based rehabilitation and psychosocial interventions. Tele-psychiatry is being brought in so that medical input is available simultaneously in different outpatient clinics. Electronic prescriptions are replacing paper based ones. In this way it is possible to look after large numbers of people with severe mental illnesses across an increasing geographical area. Currently, over 3000 people with long term mental health needs are looked after by around 600 volunteers and a small group of professionals.

#### **KN07 Adversity and Innovation: Insights from Work in War and Disaster**

**Ananda Galpatti, Mental Health and Psychosocial Support Services, Sri Lanka**

This paper draws on two decades of work on Mental Health and Psychosocial Support in situations of civil war and disaster in Sri Lanka to illustrate how adversity can be an opportunity for innovation in delivery of community services. The paper describes how the conditions of overwhelming need, limited resources and a complex, dynamic implementing environment helped propel developments in both theoretical and practical approaches to service provision in these emergency contexts. While it explores some of the factors that enabled and catalysed innovations, the paper also describes the challenges in sustaining and institutionalising some of these, both during and in the aftermath of crisis. The paper concludes with a critical appraisal of the 'Build Back Better' mantra that is now invoked in the context of humanitarian mental health responses to major emergencies.

#### **KN08 Mental health and migration research in Australia: Systemic problems and consequences**

**Professor Harry Minas, University of Melbourne, Australia**

Cultural and linguistic diversity is a core feature of the Australian population and a valued element of national identity. The proportion of the population that will be overseas-born is projected to be 32% by 2050. While a very active process of mental health system reform has been occurring for more than two decades the challenges presented by cultural and linguistic diversity have not been effectively met. A key area in which this is particularly an issue is in the collection, analysis and reporting of mental health data that reflect the reality of population diversity. A review of Australian research on mental health of immigrant and refugee communities reveals systematic neglect of the fact of population diversity and consequent constraint on capacity to develop, and to evaluate the effectiveness of, service responses.

#### **KN 09 Cultural diversity and mental health: The Canadian experience**

**Professor Kwame McKenzie, Centre for Addiction and Mental Health (CAMH), Toronto, Canada**

Canada is one of the most diverse countries in the world and it is becoming more culturally diverse. Over 250,000 new immigrants come each year. In some cities, such as Toronto, over 70% of people are first or second generation immigrants. There is a sizeable Aboriginal, Inuit and First Nations population living on reserve and in the cities. Despite all of this, developing culturally safe and Health Commission of Canada was set up. This paper will present what is known about the mental health of Canada's culturally diverse populations and what led to improving mental health services for Canada's diverse populations being included, as one of only 6 strategic directions in the first national Mental Health Strategy. It will plot Canada's progress and the development and outcomes of the recent Case for Diversity report which aims to move service development from theory into practice.

#### **KN 10 Culture and ethnicity and mental health care: An evolutionary perspective**

**Dr Riadh Abed, UK**

At first sight it may seem incongruous to speak of human biology and culture & ethnicity in the same sentence. However, taking an evolutionary perspective will demonstrate that this is a mistaken viewpoint. Culture is a universal and core human attribute that has been elaborated by our species over thousands of generations, but culture itself is not uniquely human and does exist in other species. An evolutionary perspective can clarify what is unique about human culture and what effect this has had on shaping human psychology and society. There are fascinating parallels as well as differences between biological and cultural evolution. It will be



argued that whereas the human capacity for culture has evolved through a process of biological selection, the content has evolved through the distinct process of cultural selection and that there has been an interactive gene-culture co-evolutionary process ever since. While it is evident that culture has brought with it huge advantages to our species that has allowed humans to colonise a wider range of habitats than any other mammal, it also comes with its own costs. Human culture is so pervasive that it is impossible to understand the human condition without understanding the central role it plays, but I will argue that it is not possible to develop a proper understanding of this fascinating human phenomenon without examining culture in its proper biological context. Finally, I will propose an evolutionary-inspired framework for the interface between culture and mental disorder.

#### **KN 11 Black mental health service user/survivor advocacy and activism: Yesterday, today, tomorrow**

***Dr Jayasree Kalathil, Survivor research, UK***

In the UK, since the 1970s, there has been an active mental health user/survivor movement – the coming together of people who experience mental distress and/or have been given psychiatric diagnoses for working towards personal and collective political rights. During this period, there have also been several anti-racism struggles, addressing institutional racism within mental health services and the negative racialisation processes that impact on the mental health and wellbeing of black and minority ethnic communities. Black mental health service user/survivors have straddled these two political movements in their advocacy and activism, at times working in collaboration and, at other times, addressing complex processes such as racism within the mainstream survivor movement and paternalism within anti-racism movements. This presentation will look at the emergence of and key milestones in this difficult work undertaken by mental health user/survivors from racialised communities, showcasing some of our achievements in contributing to the knowledge base on and practice of advocacy, peer support, survivor knowledge, community development and black survivor leadership. It will then take stock of social policies and political developments that have resulted in what some activists call “the state of homelessness” that the black user/survivor movement currently experiences to situate our concerns today, and point to our aspirations and on-going struggles for the future.

#### **KN 12 Cultural Adaptations of Interventions: Possibilities and Challenges**

***Dr. Shanaya Rathod, Southern Health NHS Foundation Trust, Southampton, UK***

Globalization is to live in a culturally rich and diverse society. Cultural factors play an important role in the way that people view interventions offered by health services. For this reason, practice in health services must also progress from the recognized Western traditions to incorporate the needs of culturally diverse populations. Most psychosocial interventions for mental disorders, as currently delivered, have been criticised as being West-centric and not in tune with varied cultural beliefs. As a result, people from diverse cultural backgrounds are reluctant to work with therapists, who in turn often do not have the confidence to work with people from diverse cultures. The concept of cultural relevance has, thus, become significantly more important in recent years. With the increasing realisation of the need, cultural adaptation of many mental disorders has begun but this is the beginning of the journey. The evidence to support this is explored.

#### **KN 13 Cultural perspectives and recovery**

***Professor Mike Slade, University of Nottingham, UK***

A systematic review and narrative synthesis identified five key processes involved in recovery: Connectedness, Hope, Identity, Meaning and Empowerment (the CHIME Framework). The framework will be described, including a sub-group analysis of recovery in non-majority populations. A systematic review to establish cross-cultural validity of the CHIME Framework will then be presented. However, there is emerging evidence that a culturally broader conceptualisation of recovery is needed, which places a stronger emphasis on (a) spirituality, (b) issues of stigma, inequality and the sociocultural context of mental distress and (c) a collective rather than individual-level understanding of recovery. These would go some way to addressing limitations of how ‘recovery’ is currently operationalised in mental health systems.

#### **KN 14 Dialogues between critical psychiatry and global mental health: critiques and commonalities**

***Professor Vikram Patel, Public Health Foundation of India/ Sangath India/UK***

Global mental health is a discipline which is primarily concerned with reducing the mental health treatment gap. The dominant focus has been on Low and Middle Income Countries (LMIC) where these gaps are the greatest. The efforts of the discipline are guided by two fundamental rights: the right to evidence based care and the right to a life with dignity. The foundations of global mental health are embedded in two disciplines,

viz cultural psychiatry and global health. Yet, even as global mental health has grown into one of the liveliest disciplines of global health in recent years, cultural psychiatry has been generally suspicious or, even frankly hostile, to its motives. In recent years, there have been efforts by scholars from both disciplines to bridge this intellectual gap and my talk will address some of the fundamental critiques of global mental health, notably: that in the absence of a biological marker, psychiatric diagnostic categories, particularly those of common mental disorders, lack validity; that as social determinants play a key role, therefore there is, at best, only a minimal role for individual health care; that the discipline is a front for the interests of pharmaceutical industry; and that applying knowledge generated in developed contexts to developing ones is tantamount to “medical imperialism”. I will propose that these critiques are founded on fundamental misinterpretations of the endeavours of global mental health practitioners, and fail to recognize how deep the influences of the social sciences and cultural psychiatry have had on its principles and methods. Today, global mental health has captured the imagination of a wide range of stakeholders, from consumer and civil society groups, to national policy makers to international donors and development agencies. Yet, there is still much work to be done for the denial of the rights to care and dignity remain as much of concern today as they were a decade ago. Finding the common ground between global mental health and cultural psychiatry are essential to find a united voice to spur policy makers and funders to act. To do this, we must begin by rejecting, once and for all, archaic dichotomies which have for too long bedevilled the discourse on unmet needs for care and delayed action on the ground; viz. the dichotomy is between universality and relativism; of social determinants versus biological determinants; and between diagnosis and distress. We need to focus on the many areas of agreement between these disciplines, such as: the mindless application of psychiatric diagnosis through survey tools which fail to consider context or meaning and lead to medicalization of normative distress; the ever increasing reach of a pharmaceutical industry working in collusion with psychiatrists to peddle a narrow biomedical approach to mental health problems; the recognition of great suffering due to mental health problems which must be addressed through a judicious combination of psychosocial and biomedical interventions; and the central importance of context which must be taken into account when addressing this suffering. In achieving this common ground, we also set the stage for achieving the ultimate potential of global mental health in two ways: first, reverse engineering the innovative approaches pioneered in LMIC for implementation in HIC where treatment gaps remain large in spite of far greater resources; and second, by furthering the discovery agenda which I believe has been greatly hindered by the lack of basic and translational research in the global context. In finding our common ground and joining forces, we can ensure that our shared goals, of ensuring the right to community oriented care and the right to a life with dignity for people with mental health problems in all countries can be assured. Ultimately, the goal of both cultural psychiatry and global mental health is to work together, as siblings perhaps, with the shared mission of the establishment of mental health as a global public good.

### **KN 15 A Psychosocial Model for Children who experience Trauma in Low-Income Countries** **Professor Panos Vostanis, University of Leicester UK**

Despite the increasing public and media awareness of the impact and suffering that child trauma causes, there is still substantial fear and stigma of mental ill health, as well as discrimination, which hinders efforts to promote children’s well-being. Research advances have enhanced our understanding of the extent and nature of child mental health problems among vulnerable children such as those in public care, in contact with the courts, refugees and homeless. Examples of our previous research will be presented on the impact of an earthquake in Iran, war conflict in Gaza, and socioeconomic deprivation in Pakistan. Current studies include the evaluation of child protection training in Saudi Arabia, the mental health needs of Syrian refugees in Turkey, and an intervention for children victims of ethnic conflict in Kenya.

As no single country can provide all answers and services required, even if their health and welfare systems are relatively well resourced, sharing knowledge, lessons learned and solutions can have a dramatic and large-scale impact on children, particularly those living in deprived communities and high risk environments. The consolidation of our international partnerships with academic centres, services and NGOs, as well as our outputs, led to the World Awareness for Children in Trauma programme (WACIT - [www.wacit.org](http://www.wacit.org)). So far, this has consisted of visits, training workshops model-building in Turkey, Indonesia, Pakistan, Kenya, Rwanda and Brazil. This was successful in establishing communities’ views and networks in setting up child trauma centres with limited resources. The lessons can be applied to generate wider awareness and sustainable support in other countries, and for even more remote and marginalized child populations. A number of international partners have already endorsed this project, and a preliminary evaluation is under way.

## **KN 16 Ethical and sustainable services for mental health and wellbeing in non-western settings**

**Dr Suman Fernando UK**

Ideas and concepts that are referred to as 'mental health' and 'mental illness', as well as the clinical disciplines of 'psychology' and 'psychiatry' (that inform mental health services), have developed within a western cultural framework; and hence they incorporate a particular view of the human condition and worldviews reflecting 'western values' that arose during the (European) Enlightenment. Equivalent ideas and concepts based on somewhat different notions (to the western one) of the human condition are evident in non-western cultures, but, as a result of colonialism and cultural imperialism over the past three hundred years, many of these (culturally) non-western systems have been under-developed and even suppressed. Thus, western (so-called 'scientific') psychology and bio-medical psychiatry have come to dominate the world today. During the past two decades neo-liberal economic policies and neo-colonial projects backed by power of economic forces and multinational corporations have further supported the spread of western psychiatry and psychology worldwide. Today, many places in the Global South are characterised by a variety of systems (for 'mental health') informed by both western and non-western 'psychologies' and medical ideas - a 'pluralism' of systems focused on protecting and supporting wellbeing and handling problems that are seen as 'madness' or problems of mental health. Hard data on what sort of services are appropriate and acceptable to most people in low and middle income countries (LMICs) is sparse. Lessons from a study between 2007 and 2012 (the Trauma and Global Health Program of research and capacity building) carried out in Sri Lanka as part of a wider research program in four countries in the Global South is briefly presented; and lessons are drawn from it about how mental health services are best developed in LMICs. It is proposed that the drive to develop mental health and wellbeing services in LMICs should be *bottom-up* and *home-grown*, using mainly indigenous knowledge systems (as well as appropriate knowledge from the West). Services should be responsive to the psycho-social needs of ordinary people; consistent with *their* cultures and worldviews; and sensitive to human rights including the rights of communities themselves to control development. The process of development should be *ethical* in being for the benefit of people 'as self-defining subjects' rather than 'objects of concern' and *sustainable* in being firmly embedded in social and political structures and not dependent (as in colonial times) on input from 'experts' from rich countries.

## **KN 17 Globalisation and ecological approach - between social determinants and subjectivity: the experience of Trieste**

**Professor Roberto Mezzina Director, Department of Mental Health, ASUITs, Trieste, Italy**

In high income countries today, in the context of economic crisis, poverty and social injustice propose anew the paramount importance of processes of exclusion and the nexus poverty-illness as a two-way and circular process. Nowadays new inequalities and human rights violations exasperate the individual and social suffering that are tied to material living conditions, alongside the exclusion from citizenship or forms of second-class citizenship e.g. for immigrants. Mentally ill people, everywhere in the world suffering from exclusion and lack in citizenship rights are now put beside other excluded social groups and they contribute to the global burden of suffering and disease. The WHO Mental Health Action Plan 2013-2020 recognises human rights as one its main cross-cutting principles, alongside a multi-sectoral approach and empowerment of people with MH issues and all stakeholders. Anyway the provision of comprehensive care anyway is still hindered by an on-going legitimization of asylums by much of the psychiatric establishment and policy makers worldwide. In countries such as Italy, where great reforms based on de-institutionalisation have been completed, despite several contradictions, a number of new opportunities have been opened for the fulfilment of citizenship rights. After the total closure of psychiatric hospitals that occurred 15 years ago, there is a very low compulsory treatment rate and a lower risk for re-institutionalisation. Particularly the Trieste 45-years experience is acknowledged as a WHO Collaborating Centre since 1987, and recognised as a sustainable model worldwide for service development by re-converting resources spent in psychiatric hospital, with a clear demonstration of cost-effectiveness at the system level, in a process of change of thinking, practice and services. Nowadays the MH Dept. is an open door / no restraint system of care that includes 24 hour CMH Centers with few beds each, only a 6 bed GH unit, day care and supported housing. It also provides a mainstreaming in the full range of community general health services offered to citizens at the District level. The involvement of all key stakeholders as partners (NGOs like social cooperatives for work and support, carers and users associations) for service provision in the area of social inclusion affects social determinants (housing, work, social relationships) mainly through personalised and budgeted plans of care. This promoted a "whole life – whole systems- whole community" approach, where 'integration' in a inter-multi-sectorial approach as a key word. All efforts in the care and social inclusion process aimed at enhancing the social capital of individuals and communities by making the best possible use of their resources as well as the service input, and therefore propose an "ecological" approach. Comprehensiveness and community integration came first as regards to treatment specialisation and avoid the risk of service fragmentation. Deskilling and task-

sharing, as well as task-shifting, described in low income countries practice, are operative in a western country context and proved to be effective. Theoretically, we can also argue that the action on social determinants is related to value of subjectivity that provides a meaningful context to care processes involving them. In almost every country a certain number of best practices in community mental health have grown and multiplied. These experiences can be defined as not only evidence-based, but also 'values-based'. What they have in common is the investment in the person and his/her whole experience as citizen and community member.

### **KN18 Culturally sensitive transformative practices & service models in Africa: A Nigerian perspective**

***Dr Erinfolami Adebayo Rasheed, University of Lagos, Nigeria***

Surveys conducted by the World Health Organization (WHO) have shown that huge treatment gaps for severe mental disorders exist in both developed and developing countries. This gap is greatest in low and middle income countries where about twenty-five percent of people in low- and middle-income countries who need services for mental, neurological and substance use conditions do not receive them. Several efforts had been used in different parts of Africa to scale up mental health services in order to contend with issues of stigma, paucity of mental health professionals and health facilities in providing culturally acceptable services for mental, neurological and substance use disorders. This become imperative as culture of the patient influences many aspects of mental health, mental illness, and patterns of health care utilization. Recently, WHO launched the Mental Health Gap Action Programme (mhGAP) for low and middle-income countries with the objective of scaling up care for mental, neurological and substance use disorders. This transformative mental service model is currently in use in Nigeria and some other part of Sub-Saharan Africa. This paper attempts to describe this and other transformative service models that are culture friendly in different part of Africa with emphasis on Nigeria.

### **KN19 Joys and tribulations in dealing with socio-cultural diversities in mental health practice in India**

***Professor Santosh Chaturvedi, National Institute of Mental Health and Neurosciences, Bengaluru, India***

The socio cultural diversities in mental health practice in India provide numerous opportunities and challenges. For clinicians growing up in this cultural background, it is natural to understand the vicissitudes and cultural ramifications. In today's multicultural society, assuring quality health care for all persons requires that health professionals understand how each patient's socio-cultural background affects his or her health beliefs and behaviours. Socio-cultural differences, when misunderstood, can adversely affect the cross-cultural therapist-patient interaction. Such misunderstandings often reflect a difference in culturally determined values, with effects ranging from mild discomfort to non-cooperation to a major lack of trust that disintegrates the therapeutic relationship. At the interface between culturally shaped illness and biomedical disease, there is significant potential for being lost in sociocultural translation. The concepts of folk illnesses, idioms of distress and popular hidden illnesses discuss traditional health care in the context of some of the cultural aspects of health beliefs, perceptions and practices in the different ethnic groups and rural family practices. The concept of "cultural idioms of distress" was introduced to draw attention to the fact that reports of bodily distress can serve a communicative function. Concepts of 'folk illness' and 'popular hidden illness' help us get a complete picture of the suffering and distress, and how the person, family, and society view it. This helps to promote communication and cooperation between therapists and patients, improves clinical diagnosis and management, avoids cultural 'blind spots' and unnecessary medical testing and leads to better adherence to treatment by patients. Many such presentations are considered as medically unexplained symptoms. Each culture has certain core beliefs about the body, mind and soul and also the health. Hence, the western concepts often may not be applicable directly. Popular hidden illness may be understood as an acceptable way of being ill in that society and often help is sought from the traditional healing systems. The common presenting symptoms which can be considered under the purview of idioms of distress, popular hidden illnesses and folk illnesses are fatigue, weakness of body, mind, sexual, neurasthenia, 'dhat' (semen loss) related in men and women; multiple aches and pains, musculo-skeletal, headaches, low back ache, genito-urinary, gastro intestinal like gas, constipation, digestion, bowel movements, neurological like pulling of nerves, sensory symptoms, giddiness. And many times multiple. It is interesting to note that 'medically unexplained symptoms' have acceptable 'traditional explanations' or 'folk medical explanations' and folk medicine has no 'unexplained symptoms'. A disparity in the views of medical professional and lay person is cause of distress, poor compliance, chronicity and abnormal illness behaviour. The management needs a cultural competence and sensitivity in the health professional. The assessment should include assessment of diet, activity, systems, and functioning. A cultural formulation and acceptance of the explanatory model is needed. Explanation and counselling, with rational use of pharmacology, and appropriate use of folk medicines and complementary and alternative methods are part of mental health practice by many professionals.

## **KN20 Global volunteering in mental health: Global and cultural perspectives**

***Dr Peter Hughes, Springfield University Hospital, London UK***

Most of the world lives in poor countries with huge unmet needs around mental health. First point of call for many in the world is traditional healers and religious leaders. The understanding of illness from an anthropological point of view must be considered to ensure that mental and psychosocial needs are met in a useful culturally sensitive way. Issues that need to be addressed are gender, violence, stigma, religion, tribe and economy and fit into a model of mental health that fits with local culture. We are confronted as outsiders with the accusation of being neo-imperialist, culturally insensitive and an existential issue of what UK volunteers can offer balanced with the urgent, huge unmet need. We are faced with child brides, female genital mutilation and institutionalized, national prejudices. The UK volunteer must tread a delicate pathway with a nuanced approach and be non-judgmental even when we see what is not right. I will start with some background information on global mental health and then talk through examples from disasters, conflict areas, varied cultural backgrounds. Discussion on UK volunteering, the benefits back in the UK and opportunities will be discussed.

## **KN 21 Encouraging Access to South Asians for a timely dementia diagnosis**

***Dr Naaheed Mukadam, University College, London UK***

Early diagnosis of dementia is a National Dementia Strategy priority. It can improve outcomes for people with dementia and carers by enabling treatment, support and the opportunity to plan for the future. At present, people from minority ethnic groups access dementia services later than the White UK population and my previous research has shown this is likely to be due to cultural differences. I carried out further qualitative research to explore what kind of intervention South Asian community members would find helpful in encouraging earlier help-seeking for dementia. I used my findings to develop an educational intervention to encourage South Asian people to seek help earlier for dementia. I am currently carrying out a cluster pilot randomised controlled trial to test the intervention's feasibility and acceptability, as well as scores on a Theory of Planned Behaviour questionnaire. If successful, this intervention could improve access to specialist dementia services for South Asian people with dementia, which would enable better care planning and would avoid crises.

## **KN 22 Dementia Care for diverse cultural communities**

***Professor Sab Bhaumik, Leicester Partnership NHS Trust, Leicester UK***

This talk will focus on the current global situation in relation to dementia with a focus on the developing world and care costs across the world. Also discussed will be approaches to prevention and early prevention, and the applicability of these approaches for diverse cultural communities. The final section will focus on social impacts on family and understanding the basic principles of applying the social model of understanding the underlying symptoms and conditions which can be used effectively in all culturally diverse communities.

## **KN 23 Understanding Extreme States through the language of post psychiatry**

***Olga Runciman Psychologist (Denmark)***

Attitudes towards mental distress vary among people from different cultures, ethnic backgrounds and countries. The typical label schizophrenia, which is given to extreme states by academic psychiatry in the western world, has created a subculture where discrimination, human rights abuses and stigmatization are rife. The hearing voices movement has risen out of this discourse situating itself firmly within a post psychiatric dialogue opening up spaces and giving voice to those who have previously been silenced. By examining extreme states through the language of post psychiatry we open up for other interpretations and understandings which contradict the socially condoned explanation given by the dominant society. Thus the hearing voices movement has, by giving voice to the many dreadful narratives of trauma and abuse, introduced a language of suffering that challenges the diagnostic definitions and symptom descriptions of academic psychiatry. In doing this the hearing voices movement introduces meaning into the perceived meaninglessness of extreme states not just for the sufferers themselves but also for those who care for them. This means that significant changes can be created within communities and systems wishing to support people recover if partnerships are put in place between those with the lived experience of extreme states, their family and friends and mental health practitioners, researchers and policy makers.

## **KN 24 Imagining culturally competent mental health care**

***Professor Raghu Raghavan, De Montfort University, Leicester, UK***

People from minority ethnic backgrounds in the UK generally have worse health outcomes and experience higher poverty than the general population, with variation between and within different ethnic groups. Ethnic

differences in mental health care are controversial. Black and Minority Ethnic service users are more likely to receive a diagnosis of mental illness than a White British person. There is evidence of ethnic differences in risk factors for mental illness, such as discrimination, social exclusion and urban living. There is also evidence of differences in treatment. For example, Black Caribbean and African people are more likely to enter psychiatric care through the criminal justice system than through contact with the health services. We also know about severe lack of reliable service planning information on the mental health needs of BAME (Black Asian and Minority Ethnic) children and young people and their families. The recent All Party parliamentary Group Report on Dementia in BAME communities recommend that health and social care services should identify their needs and to develop culturally appropriate services. Cultural insensitivity of our Health and social care services leads to a lack of service engagement with users. Indeed the barriers for service access, utilisation and ways of promoting better outcomes for BAME communities has been well researched and a considerable body of evidence exist for improving culturally appropriate and acceptable services. However, the lack of a comprehensive and joined up synthesis of evidence to influence service change leaves our policy makers and service providers continually articulating the disparities in BAME mental health. The structure and operation of services, the way health professionals and social care professional are trained to see users and the way mental health symptoms are conceptualised in our health care settings have all been argued to entrain disadvantage for BAME communities. Understanding these processes is important for the development of effective policies and practices to reduce the health disadvantage experienced by people from BAME communities. This call for action for developing cultural competency and this presentation will focus on developing cultural competency in our health and social care workforce.

## **KN 25 Human Rights, mental health and human dignity**

### ***Dr Albert Persaud (UK)***

It is often said that the true test of a decent society is the way it treats its most vulnerable citizens. However, too often, politicians, policy-makers, professionals and those others with the authority and duty to protect and provide for them, fail to do so. People with mental health problems are often subjected to serious abuses, such as chaining, and in some countries denied fundamental human rights and protection through proscriptive laws. Mental health problems account for almost 13% of the world total disease burden, affects up to 10% of people across the life course at any one time and make up over a quarter of the years people live with disability globally. In total, mental health problems cost the world some US\$2.5 trillion per year rising to US\$6 trillion in the next few years; yet the amount invested to treating mental health problems is barely a fraction of this - less than 2% of the total health spending in most low and middle income countries. This presentation will give an overview of mental health legislation in some Countries and outline how cultural psychiatry can impact change.

## **KN 26 Ten years of NOT Delivering Race Equality in Mental Health in England- Where do we go from here?**

### ***Professor Shashi Shashidharan (UK)***

Profound and persistent ethnic inequalities have been an enduring feature of mental health care in England. In 2005, the Department of Health in England set out an action plan for reform, inside and outside services, for achieving race equality and tackling discrimination in mental health services - *Delivering Race Equality in Mental Health Care (DRE)*. My presentation will consider the antecedents to DRE. I will also review the outcome of DRE, specifically in relation to the targets set out in the action plan. I will argue that the patterns of ethnic inequality in the experience and outcome of mental health care in England remain largely unaltered, despite the specific and explicit intentions of the DRE programme. My paper will provide an analysis of the failure of DRE and consider meaningful options for tackling ethnic inequalities in mental health care in England.

# ABSTRACTS

## CONCURRENT SESSIONS and WORKSHOPS

22 June 2016

### OP1

#### The multilingual experience: Where is it?

Costa B, Mothertongue multi-ethnic counselling and listening service, Reading, UK  
([beverley@mothertongue.org.uk](mailto:beverley@mothertongue.org.uk))

**Introduction:** According to 2011 UK Census data, 4.2 million people (7.7%) in the UK speak another main language besides English. Although there is increasing interest, the role of language in therapy for multilingual patients and for multilingual therapists has attracted relatively little investigation. A therapist's or a patient's bilingualism can both promote and adversely affect the therapeutic process. Mainstream psychotherapy tends to ignore these experiences. **Aim:** To address this gap in services for black and minority (BME) communities in the UK, Mothertongue multi-ethnic counselling service was formed in 2000 to provide culturally and linguistically sensitive counselling. **Method:** This paper will give an overview of the work of Mothertongue as well as our cross disciplinary research with Birkbeck, University of London. This research aims to open up the discussion about multilingualism and therapy; to listen to and to convey the voice of the multilingual patient; and to compare and contrast the views of multilingual patients with the views of multilingual therapists. **Results and conclusions:** The results so far reveal that: (1) Multilingual patients are different from monolingual patients (with the implication that attention needs to be paid to this in therapy) (2) People may access emotions in a second language that have been inhibited in the patient's first language (3) Traumatic scenes experienced in one language may be explored more readily initially by switching to another language for their narration, in order to gain sufficient emotional distance to begin to process the experience. Training initiatives based on these results, evaluated in 2015 and include the recommendation that traditional psychological therapy trainings need to be revised to incorporate the multilingual experience.

#### Collaborating with providers to uncover and address racial inequalities to enhance mental health service provision

KONIDARIS M and PETRAKIS M, Monash University, and North Western Mental health, Melbourne, Australia

**Objective:** This research aims to enhance self-awareness in mental health service provision related to issues of race and racial inequalities. Helms (2015a) suggest attending to this dynamic and its impact on mental health service provision, reflects enhancing awareness and a shared responsibility between the client, and service provider. In Australian health services, these concerns remain predominantly covert and unaddressed. Inspiration and learning however, is drawn from Aboriginal education and research initiatives related to harmful effects of racial tensions and racism health service settings. **Method:** The methodology aims to develop culturally based education and training for mental health service providers utilizing a cultural humility framework. Key informants will be approached to guide, provide relevant expertise and enhance the development of the project. **Results:** Research results aim to challenge and enhance providers' awareness around implicit and explicit racial bias, and negative cultural stereotypes. It aims to promote equity and social inclusion in organizational processes and policies. It may enhance the accuracy of psychiatric assessments and diagnoses, leading to the implementation of more appropriate treatments. It may improve therapeutic engagement, trust and rapport building resulting in improved medication compliance. It may alleviate the propensity of triggering additional depression and anxiety symptoms, commonly associated with implicit racial bias in organisations or setting-specific racism (Ferdinand, Paradies, & Kelaher, 2015). **Conclusions:** Utilizing cultural humility based dialogue in training will promote and enable the hard conversations and challenge racial biases and negative cultural stereotypes, utilizing self-reflection as the critical tool towards enhancing racial literacy and clinical outcomes.

## OP2

### Spirituality and meditation as mediating factors in Black families' well-being

Ochieng B, School of Health and Social Care, London Southbank University ([ochiengb@lsbu.ac.uk](mailto:ochiengb@lsbu.ac.uk))

**Objectives** Whilst a growing number of studies have reported fairly consistent positive relationship between spirituality and coping with negative life experiences, little attention is paid on the role of spirituality in helping Black families maintain good mental health and their wellbeing. My presentation critically examines the influence of spiritual beliefs and the practice of meditation on Black families' wellbeing and mental health. **Methods** The material is drawn from a community-based ethnographic study exploring the healthy lifestyle attitudes and experiences of Black African adolescents and their families. Ten Black families' including eighteen adults with age range thirty-nine to sixty years, and twenty-three adolescents with age range twelve to seventeen from the north of England participated in the study with interviews conducted in their homes. **Results** The findings provided evidence as to how spirituality and meditation may impact upon individuals' mental health and wellbeing. Families described how against a background of negative life experiences, it was their spiritual beliefs and meditation that seemed to sustain a positive outlook to their lives, mental health and wellbeing. **Conclusions** While the overall connections between spirituality and beliefs on mental health and wellbeing warrants further investigation, the findings suggested the need for integration of spiritual beliefs on mental health and wellbeing programmes.

### Spiritus contra Spiritum: Including Spirituality in addiction treatments for recovery: a systematic review

Ossorno Garcia S, Babarro J M, Romero M P T ([santiago.de.ossorno@gmail.com](mailto:santiago.de.ossorno@gmail.com))

**Introduction:** Spirituality had been acknowledged as a key construct to observe in the treatment and recovery from addictions. Due to the individualistic nature of the construct and overlap with religion, it is still not clear how spirituality influence treatment and recovery of individuals. Different treatments and approaches like AA philosophy or spiritual practices embrace the whole construct to obtain better outcomes in recovery for addictions. **Aim:** The aim of this review was to examine the effects of this construct and its relationship with recovery. **Method:** A search strategy was followed to retrieve 457 scientific papers related with the matter of study. A total of 14 studies were selected and assessed for quality. Experimental and observational studies were categorised by design, and reviewed through narrative synthesis. **Results:** Results showed that due to the lack of experimental research, poor quality and diverse conceptions of the construct, spiritual treatments are not more effective than other treatments whereas high levels of spirituality and spiritual practices tend to reduce the substance use outcomes and improve in other areas of recovery. **Conclusion:** From the findings reviewed which need to be considered with caution, it was concluded that implementing this construct within the therapy or approach may improve, in many cases, to achieve a successful recovery. More research is needed to determine if spiritual-related treatments have better outcomes, and some recommendations were addressed for future research, in addition to an encouragement for the inclusion of spirituality with its diversity into different domains of clinical practice.

### Religious identity and its influence of religious discourse in mental health

Mitha K, Edinburgh Migration, Ethnicity, and Health Research Group (EMEHRG)/Alwaleed Centre for the Study of Islam in the Contemporary World, University of Edinburgh ([k.mitha@sms.ed.ac.uk](mailto:k.mitha@sms.ed.ac.uk))

**Objective:** Little work has examined the influence of identity on religious based discourse in mental health, and how this is attenuated by interactions with Muslim patients and the general population. This study examines identity processes of Muslim religious leaders/imams and clinicians to see if situational context influences affects discourse of mental illness within a religious paradigm. **Method:** Participants were Muslim clinicians and mental health workers (n= 10) as well as religious leaders/imams (n = 10). Participants were obtained through both purposive and snowball sampling through NHS trusts and religious community centres in Scotland and London. Qualitative data was analysed via thematic analysis. **Results:** Preliminary results suggest regional variations Scottish Muslims asserting their religious identity, whilst English Muslims primarily affiliate with their ethno-cultural identity. Nevertheless, all participants felt being Muslim played a crucial role in their identity. Religious leaders/imams felt scrutinised and pressures of Islamophobia and clinicians felt their professional role placed greater pressure whilst enabling them to educate others about Islam based on their actions. There appeared to be no relationship between religious identity and religious models of mental illness. **Discussion/conclusion:** It may be that due to greater cultural diversity in London, affording greater



religious support networks, participants felt different from the majority by virtue of their ethnic background whereas Scottish Muslims felt more isolated and thus their religious identity was a primary marker of difference. Nevertheless, both groups felt a sense of difference vis-à-vis the outgroup. This, however did not appear to affect religious views of mental health suggesting these views are independent of strength of religious identity.

### OP3

#### **EDAWU: A Journey from in-patient rehabilitation to a focus on community treatment and involvement**

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([Nandini.Chakraborty@leicspart.nhs.uk](mailto:Nandini.Chakraborty@leicspart.nhs.uk))

**Objectives:** This presentation is a narrative one which describes the training of staff in a psychiatric service in rural Nigeria (Edawu) by mental health professionals from the UK and Lagos which has helped staff from Edawu start a systematic process of mental health awareness in the local community to promote treatment of mental illness in the community versus inpatient settings. **Methods:** In 2016, 3 mental health professionals- a psychiatrist and an occupational therapist from the United Kingdom and a psychiatrist from Lagos, visited Edawu over a two week period. They facilitated staff workshops which focussed on developing a community mental health awareness programme, delivered lectures on mental illnesses, psychiatric history taking, diagnosis and treatment plans and encouraged role play to consolidate staff skills. **Results:** The staff gained knowledge of the different types of mental illnesses-identification and treatment. They were confident in relaying this knowledge to the community. They formulated distinguishing criteria for people who would still require in-patient treatment versus those who could be treated in the community. They had a clear time limited agenda for the first catchment area they would target for starting the mental health awareness programme. **Conclusion:** The project is expected to promote better acceptance, de-stigmatisation and rehabilitation of people with mental illnesses with the participation of local communities. We hope that there will be at least 25% increase in attendance in clinics, 50% reduction in average in-patient stay and education of at least 5000 lay people in the community about mental illness within a year.

#### **Partnership working in Ethiopia**

Wroe L, Dipple H, Leicester Partnership NHS Trust, Leicester

Ethiopia has long-established and distinctive traditions, but is one of the four poorest countries in the world. In Gondar, the Leicester-Gondar Link is supporting developments in the undergraduate and postgraduate teaching programmes and has contributed to local plans to enhance health care in the hospital and in the urban and rural communities. The Leicester-Gondar Medical Link started as a result of health professionals in Leicester wanting to make a difference in the developing world and the strongly supported Link with The College of Medical Sciences in Gondar was established in 1996. Over the years, there have been many projects that have been beneficial to both Leicester and Gondar including a fully independent Master's degree in Public Health training health workers from all over Ethiopia. In 2004, when the College of Medical Sciences developed into the University of Gondar, it was decided for the University of Leicester to become involved. A Memorandum of Understanding was then signed between the two institutions, giving rise to the Leicester-Gondar University Link. The aim of this link is to promote international fellowship and friendship, mutual respect, improved communications and cross cultural working leading to joint research and mutual development and support. In 2008 the Leicester-Gondar Medical Link achieved independent charity status as Health Action Leicester for Ethiopia (HALE).

#### **Learning disability Partnership working in India**

Satheesh Kumar, Leicester Partnership NHS Trust, Leicester ([Satheesh.Kumar@leicspart.nhs.uk](mailto:Satheesh.Kumar@leicspart.nhs.uk))

Our Learning Disability Link works across three sites in India, one of which is a centre for children and adults in Hyderabad. Staff with a range of skills and expertise visits the link to give practical advice and training, including staff from speech and language therapy, and specialist nurses and doctors. The work in India has a strong emphasis on education and training. An ongoing multi-disciplinary training programme has been developed and our staff work closely with medical colleges in Kolkata and Bangalore to deliver medical training and influence government policy through the national curriculum. India project is currently focussing on the MhGap route. There was one training in Kottayam Kerala, Nov last year. About 50 health staff were trained using the MhGap manual on LD and mental health. We received good publicity for doing locally and

reported by all the local popular media. This was done in partnership with the local medical school and its psychiatry department.

## OP4

### **Dementia support and understanding within the South Asian community: The Sakthi project**

Sitaram B and Chakrabarti S, Leicester ([bina@earthbuds.co.uk](mailto:bina@earthbuds.co.uk))

**Objectives:** Shakti provides support to individuals affected by Dementia, in the form of emotional support and practical advice, as well as delivering community outreach talks to help raise awareness around Dementia and mental health. 12 months on and the need to increase the awareness around support available and also recognising early symptoms is priority and evident. **Methods:** One to one verbal support over the phone has proved to be the preferred route of support from service users and home visits. Family members of patients access this support service stages range from early to late usually when family has arrived at some crisis point in dealing with the progression and care of patient. The support offers advice on areas such as: home care, legal and financial arrangements which should be implemented, emotional support, social services, day care. Community talks focus on acceptance of mental health problems in order to break down barriers and stigma, early symptoms of dementia and brief overview of diagnostic and care pathways. A strong bond has also been formed with other support services such as Alzheimer's society. **Results:** A positive impact which has been made to individuals in helping to deal with their journey with Dementia, as well as an increased understanding of the disease and also a heightened awareness of other support services available. The main objective was to relieve the feeling of being alienated. **Conclusion:** to make this support available on a wider scale regionally & nationally. To meet the specific needs of the support required by the South Asian community, so providing culturally sensitive support and advice and also assisting in developing culturally sensitive diagnostic tools and pathways / strategies

### **Aging well in Indonesia: Meeting the mental health needs of elderly Indonesians**

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**Introduction:** Indonesia has a population of 21 million persons aged 60-and-over and this number is projected to rise to 48 million in 2035. There has been little analysis of the policy ramifications for both government and service providers flowing from this demographic shift particularly in the area of health and mental health provision. A comprehensive understanding of the unmet health needs of Indonesia's elderly is essential for providing targeted service provision to those most vulnerable. From the international literature, depression is the second highest cause of disability for all age groups worldwide. **Aim:** This paper will present an analysis of the mental health needs of Indonesia's rapidly expanding aging population using both existing national level datasets (RISKESDAS and the Indonesian Family Life Surveys) and a three village survey of 60 and over-year-olds. Although prevalence levels of depression in the US, UK and Australia are lower in community samples aged 60 years-and-over than the general population, preliminary estimates from the 2007 and 2013 Indonesian Basic Health Surveys (RISKESDAS) suggest the trend for Indonesia is in the opposite direction with this age cohort being almost twice as likely to be suffering probable depression/anxiety type symptoms compared with the general Indonesian population. Comorbid physical ailments are also common adding complexity to care arrangements. **Method:** The three village survey was undertaken September/October 2015 as the pilot phase of a larger Australian Research Council funded national survey of Indonesia's older persons modelled after the US Health and Retirement Survey (HRS) and the Survey of Health, Aging and Retirement in Europe (SHARE). This study included a full enumeration of almost 900, 60 and over-year-olds, and 300+ relatives/carer and service provider interviews across three Indonesian provinces. **Results and Conclusion:** The survey included a comprehensive health module, with targeted questions for mental health assessment. Levels of depressive and anxiety symptoms and probable disorder are reported, as are rates of cognitive disturbances embedded in a larger discussion on complexities of cross-cultural assessment. In addition to prevalence estimates, predictions of mental illness, relationship with disability, as well as utilized, available and ideal treatments are also discussed in order to better identify opportunities to fulfil unmet needs amongst the growing number of Indonesia's elderly.

## Working with migrant communities: Achieving cultural competency in dementia care

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Research on dementia care in Black, Asian and Minority Ethnic (BAME) communities has highlighted the need for the need for cultural competency training for those working professionally with people with dementia and their families. It has been evidenced that while many health professionals feel that they need more training to both improve their knowledge about dementia and the cultural norms and religious practices of BAME people with dementia, access to this sort of training is variable. Because of the acute lack of quantitative and qualitative data about the health and social care needs of BAME communities, and how they are best met, training to improve cultural competency in services is difficult. Whilst training for basic Asian language communication skills is useful, the diversity both between and within BAME communities also needs to be addressed. This paper reports the findings of research with Sikh carers of a family member with dementia living in Wolverhampton in the UK – highlighting evidence that demonstrates the diversity of the Sikh community and challenges assumptions of homogeneity. The findings of this research demonstrate the need for health care professionals and service managers to apply a person-centred approach to care when working with people with dementia and their families from migrant communities in the UK. Cultural competency is a contested term with various understandings and definitions. This paper will present the evidence base to support the notion that cultural competency refers to an understanding of diversity and represents a value-based perspective that recognises individuality – similar to that of person-centred care.

## OP5

### Mental Health Disorders in Children and Adolescents with Intellectual Disabilities in Egypt

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**Objectives:** The objectives of the study were to examine the prevalence of mental health disorders in children and adolescents with intellectual disabilities (ID) in Egypt and to investigate the risk factors attributable to mental health disorders in this population. Method: Reiss Screen for children's dual diagnosis (Reiss & Valenti-Hein 1990) was applied to 70 children and adolescents with ID from Zagazig City in Egypt. Those aged 3 - 20 years (50 males, 20 females), with a mean age of 12.5 years (SD= 4.2). **Results:** Results indicated that the prevalence of mental health disorders in children and adolescents with ID in Egypt was 62.8%. The highest aggregate scores were in anger (42%), attention deficit (32.8%) and anxiety (28.5%), while the lowest was for conduct disorders (14.3%) and self-esteem (5.7%). Findings identified that the older children experienced high rates of mental health disorders than youngsters. Level of disabilities, gender and socio economic position have been identified as risk factors for mental health disorders among children and adolescents with ID. **Conclusion:** The results highlighted that the prevalence of mental health disorders is significantly higher among children and adolescents with ID in Egypt. The findings are consistent with earlier research that has demonstrated high prevalence rates of mental health disorders in this population

### The views of family caregivers on deinstitutionalization of psychiatry in Russia

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**Objective** As part of the major political and social transformations that followed the collapse of the Soviet Union, the Russian Federation has initiated reforms of the mental health care system. Soviet psychiatry was sharply criticized for restriction of patients' rights and over-institutionalization. New post-Soviet policies were formulated with reference to World Health Organization principles. **Aim:** The purpose of this study was to explore the views of family caregivers on deinstitutionalization reforms in Russia. **Method:** Qualitative interviews were conducted with 20 family caregivers in a large city in the Russian Federation. The data were analyzed using thematic analysis. **Results:** The results revealed that the carers appeared very restrained in supporting the reforms. They experienced feelings of confusion and lack of knowledge about deinstitutionalization. They also expressed uncertainties for the future of their relatives due to possible reforms. Although the carers criticized the current situation in psychiatric hospitals, such as large wards, poor nutrition and rude nursing staff, they recognized that hospitalisation gives them some respite from their caring role. All interviewed caregivers reported their overburdened with care due to lack of social support and community-based services. They also pointed to negative attitudes towards people with mental health problems in the community. They suggested that public attitudes would have to change before the reforms could be implemented. **Conclusion:** We think that the carers from Russia have good reasons to doubt the

reforms because in many cases they are not accompanied by proper funding, development of community-based care and activities to prevent stigmatization.

### **The Big Five Factor Model of Personality Traits and Psychological Resilience of Special Education Needs teachers in Egypt.**

Radwan F, Gobrial E, University of Zagazig, Egypt ([ereny.gobrial@hotmail.co.uk](mailto:ereny.gobrial@hotmail.co.uk))

**Objectives:** This study aimed to investigate the level of psychological resilience of special education needs teachers (SEN teacher) and to identify the association between the big five model of personality traits related to a high and a low level of psychological resilience. **Method:** Resilience questionnaire for special education needs teacher (Radwan, 2015) was applied to 80 SEN teachers from School of Education, Zagazig University in Egypt. The participants aged 19 - 24 years, with a mean age of 20.5 (SD= 3.53). **Results:** The findings illustrated that 66.25% of SEN teachers in Egypt showed high level of psychological resilience. The results indicated statistically significant positive correlation between psychological resilience and extraversion ( $r = 0.22$ ,  $p < 0.05$ ), while neuroticism has shown to be negatively associated with psychological resilience ( $r = -0.235$ ,  $p < 0.05$ ). The association between the big five factors of personality traits included extraversion, agreeableness, conscientiousness, neuroticism and openness to experience attributed to high and low level of psychological resilience will be discussed in details. **Conclusion:** The importance of teacher resilience is being key for outstanding teaching. This study suggested that personal qualities associated with high level of psychological resilience such as agreeableness and extrovert should the responsibility of providers of teacher training program to promote psychological resilience among SEN teachers.

## **OP6**

### **Innovating on the Frontline: Developing a Novel Child Sexual Exploitation Service in a High Profile Area**

Farooq R, Rodrigues T & Hickey N, Catch 22, London ([romana.farooq@catch-22.org.uk](mailto:romana.farooq@catch-22.org.uk))

Child Sexual Exploitation is currently a public and government concern; however existing services and systems have struggled to support and engage children, young people and families affected by CSE. More recently there has been a growing interest in developing new therapeutic services and models to meet their needs. The following presentation will outline an innovative new therapeutic model which has been co-developed with children, young people, families and partner organisations to meet the mental health needs of those affected by CSE. The presentation will also outline some of the transformative and emancipatory practices that the new service model attempted to embed within existing systems in order to create systems change. The presentation will outline the service and therapeutic model drawing on ideas from emancipatory practice, social justice, community psychology and mentalization based treatments.

### **Missing Voices: Minoritised Communities & Child Sexual Exploitation**

Farooq R, Rodrigues T & Hickey N, Catch 22, London ([romana.farooq@catch-22.org.uk](mailto:romana.farooq@catch-22.org.uk))

The voices of Black, Asian and Minority Ethnic (BAME) young people are often seldom heard in services, but most notable is the deafening silence concerning this vulnerable group in the existing body of work on child sexual exploitation. The Muslim Women's Network described the voices of BAME girls as "unheard" and that statutory services were overlooking them. In addition the Alexis Jay report highlighted that statutory services needed to do more to engage with minoritised communities, however what this may look like in practice is still a bit unclear. Therefore the following presentation is one of the first to privilege the missing voices of BAME children, young people and their families who have experienced child sexual exploitation and grooming. Narratives of BAME girls will be shared as well as their experience of current services and how they "fell through the net". The presentation will also highlight narratives of BAME communities and their views on how services could better meet their needs.

### **Co-Developing Youth Participation in Risk-Averse and Chaotic Systems: Challenges & opportunities**

Farooq R, Rodrigues T & Hickey N, Catch 22, London ([romana.farooq@catch-22.org.uk](mailto:romana.farooq@catch-22.org.uk))

The voices of young people should inform the design, development and delivery of services. However the voices of some young people, particularly those labelled with "child sexual exploitation" can often remain at the margins. The seldom heard narratives of young people affected by CSE can be extremely useful to services particularly around ways in which services could improve to better meet their needs. However youth

participation with young people affected by CSE is an alien concept in most multi-agency settings. Therefore the following presentation will outline some of the opportunities and challenges when attempting to embed youth participation within restrictive and risk-averse systems such as social care, the police and other multi-agency settings. The presenter will also discuss how co-developing youth participation with key stakeholders which include young people themselves can bring about small shifts in systems where usually voices of the disadvantaged are never heard. Using ideas from empowerment theory, feminist practice, social justice and community psychology the presentation will outline a framework for youth participation within systems where youth participation may not be a norm.

## Workshops

### WS1

#### **Cultural competence in Practice: Are you compliant?**

Kolapo T, Middlesex University, London ([tkolapo8@gmail.com](mailto:tkolapo8@gmail.com))

To further enhance the status of cultural competence in MH practice by assisting attendees to explore their 'real' levels of cultural competence and enabling participants to improve or gain culturally competent skills that translate into practice. I will define culturally competent care as care that is appropriate to deliver to a global population regardless of culture or ethnic background. It is care that respects human rights and is delivered according to the culturally assessed needs of the service user and carer. Health care professionals are finding evidence that a significant cultural mix in the current demographics of the UK has changed how health and social care services need to be delivered. This in turn has placed a higher demand on specialist health services by those who are living longer with long term conditions (depression), those previously healthy living to a more advanced age with a comorbidity and dementia, those with a dual diagnosis of substance misuse and MH issues, immigrants from war torn countries (PTSD) etc. This means that there is an urgent need for MH services to be culturally competent in relation to commissioning, provision and policy and practice. At present 4 levels of culturally competent care/skills are recognised all of which need to be present at the highest proficiency for a practitioner to be competent in delivering a culturally competent service.

### WS2

#### **Mental Health Issues among the Black and Minority Ethnic (BAME) and men who have sex with men (MSM)**

Dada M, London ([mehboobdada@gmail.com](mailto:mehboobdada@gmail.com))

There is significant evidence demonstrating large areas of unmet need within mental health of lesbians, gay men, bisexual and trans-communities. These are needs that are not merely ignored or marginalised, but are made invisible. Without culturally sensitive knowledge towards developing public health policy, mental health care and services for BME Lesbian Gay Bisexual & Trans (LGBT) MSM communities tend to be unaware of basic facts. This lack of knowledge creates myths and stereotypes, which are mistaken for facts and are used as a basis for diagnosis.

#### **The workshop is designed:**

- To understand the implications and effects of being a sexual minority within in a racist, heterosexist, homophobic, Islamophobic society etc.
- To raise the profile of mental health issues in the BAME GB&T MSM communities
- To incorporate within public health debates, the needs of service users from within the BAME LB&T communities

#### **Access to Mental Health Services:**

- Views on public health education and services and how inclusive they are around BME GB&T MSM communities. If they are inclusive and accessible, how do you think this is achieved? If they are not accessible, in what ways could this be improved?
- How comfortable do BME GB&T MSM communities feel coming out as a user of mental health services?
- What is the level of awareness re BME GB&T MSM?



# ABSTRACTS

## CONCURRENT SESSIONS and WORKSHOPS

23 June 2016

### OP7

#### Suicide first aid guidelines for people of immigrant and refugee backgrounds

Colucci E, Queen Mary University, London; Minas H, University of Melbourne, Australia  
([e.colucci@qmul.ac.uk](mailto:e.colucci@qmul.ac.uk))

**Objective:** During this presentation the authors will launch and discuss the tool *Suicide First aid guidelines for people of immigrant and refugee backgrounds*. The guidelines were designed to help members of the public to provide first aid to someone who is at risk of suicide. The role of the first aider is to assist the person until appropriate professional help is received or the crisis is resolved. **Method:** A Delphi expert consensus process using an on-line questionnaire containing possible first aid actions. **Results:** Forty-four professionals and/or advocates with lived experience were asked to rate whether each action should be included in the guidelines and to suggest additional actions that were not included in the original questionnaire but were considered by the respondent to be particularly relevant to a person from an immigrant or refugee background. The Delphi process started with 492 statements, 80 new items were written based on suggestions from panel members and, of these 572 items, 345 met the consensus criterion. These suicide first aid guidelines for people of migrant and refugee backgrounds were based on guidelines we previously developed for Asian countries <https://mhfa.com.au/resources/mental-health-first-aid-guidelines#mhfaasia>. **Conclusions:** Although the guidelines are designed for members of the public, they may also be helpful to non-mental health professionals working in health and welfare settings.

#### Ethnicity, immigration and schizophrenia: an evolutionary link

Abbas M, Leicester Partnership Trust, Leicester [Mohammed.Abbas@leicspart.nhs.uk](mailto:Mohammed.Abbas@leicspart.nhs.uk)

The supposed universality of the incidence and prevalence of schizophrenia has been seriously challenged. It is now widely accepted that the life-time prevalence and incidence of this disorder vary considerably in time and place with higher rates in immigrants and ethnic minorities. As a result, there has been renewed interest in the social causation of schizophrenia. There are few extant formulations that have successfully integrated the available new evidence into a coherent theory for its causation. The Out-group Intolerance Hypothesis (OIH) is an attempt to integrate this evidence. It proposes that schizophrenia is the result of a mismatch between the social brain as shaped by evolution and the new social conditions of the post-Neolithic. The hypothesis can provide an explanation for (i) the higher risk to migrants, (ii) the ethnic density phenomenon, (iii) the increased risk to individuals who have grown up in cities, (iv) the putative low risk in primitive societies, and (v) the putative secular trend of increasing risk in Europe over the past few centuries. Evidence is presented from a range of disciplines and sources including epidemiology, psychopathology, social psychology and clinical trials in support of this hypothesis. A range of testable predictions follow from the hypothesis.

#### Finding our way: stories of recovery from people with lived experience of mental health issues from migrant and refugee backgrounds

Colucci E, Queen Mary University, London; Minas H, University of Melbourne; Susan McDonough, Victorian Transcultural Mental Health, Australia ([e.colucci@qmul.ac.uk](mailto:e.colucci@qmul.ac.uk))

**Objective:** Understandings of emotional distress and mental ill-health vary considerably across cultures and immigrants and refugees have their own needs and preferences when these issues arise. There are very lively discussions underway among mainstream mental health service providers about ways to ensure that persons affected by mental ill-health are involved in directing their own care and treatment, often described as applying the principles of 'recovery'. However, how these principles apply in the context of a culturally diverse society such as Australia and UK is not well understood. This project contributes to an understanding of the cultural contexts of 'recovery'. **Method:** The authors co-coordinated the project Finding our way, where ten people from migrant and refugee backgrounds learnt to create their own digital stories about their

recovery journeys, which they titled 'Finding our way'. **Results:** Each person wrote, voiced, created and edited their film during a four-day workshop. During this oral communication, the authors will screen and discuss some of the short-films produced in this project <http://www.mhima.org.au/finding-our-way>  
**Conclusions:** The development of 'recovery-based' services need to consider the experiences of people from culturally-diverse backgrounds. Creative methods such as digital stories and films offer a useful and powerful tool to access and share these experiences and stories.

## OP8

### **Conceptions of Mental Health within the Punjabi Sikh Diaspora Community in Ottawa, Ontario, Canada**

Singh N, Wahoush O, Joseph A, McMaster University, Ontario, Canada ([nishi19@gmail.com](mailto:nishi19@gmail.com))

**Objectives:** There is scant data on the use of mental health services by ethnic minorities in Canada. This study is a preliminary investigation into why certain South Asian populations in Canada may not be accessing mental health services, focusing on conceptions on mental health. Study population is individuals claiming a Punjabi Sikh identity in Ottawa, Ontario. **Methods:** Six semi-structured interviews were conducted during the month of July 2015 with individuals residing in Ottawa who claim a Punjabi Sikh identity. **Results:** Participants often described mental health in terms of mood disorders and anti-social behaviour rather than anything resembling psychoses. Life stresses were a common cause of mental illness. All participants believed in individual agency in maintaining mental health but had differing views about the role of the community in supporting positive mental health. Younger participants perceived hindrances within the community, particularly with communication. Some hindrances were not reported stemming from religious values but rather specific cultural ones, such as differing emphasis for what belongs to the individual or family, what is private or public. The assumption that diaspora communities maintain links to India for mental health proved false. **Conclusion:** Globally, data regarding South Asian subpopulations and mental health has been inconsistent. Reasons for this include recruiting different populations under the label of \"South Asian.\" What begs further investigation are the cultural beliefs or practices that shape the relationships within diaspora communities in Canada and how these may prevent those who wish to seek mental health services from doing so.

### **Risk factors in the integration of migrant youth in Western countries**

Robinson L, Central Queensland University, Australia ( [l.robinson@cqu.edu.au](mailto:l.robinson@cqu.edu.au) )

Over the last two decades, there has been an increase in the number of people migrating to Western countries. For instance, immigration is the main reason for U.S. population growth. Based on the current rate of immigration, U.S. population will increase substantially by 2050 and more than fifty per cent of this growth will be either the direct or indirect effect of immigration (Segal et al., 2010). In Australia, it has been estimated that by 2050, 85% of Australia's population growth will be either from overseas migration or from native born Australians who have at least one foreign-born parent. There is hardly any large society that is presently ethnically homogenous as a result of migration. This paper explores some of the issues related to the adaptation and integration of first and second generation South Asian adolescents into the host society. It draws on the author's research in Western societies. How do South Asian youth manage to live in two cultures? Intercultural factors explored include ethnic and national identities; self-esteem; acculturation; and perceived discrimination. Adolescents who are members of second or later generations are likely to be well acquainted with the mainstream culture, but may face conflicting demands due to differences between mainstream values and those of their ethnic culture. The issue they must resolve is the way to combine these competing identities; that is, the extent to which they identify with their ethnic culture and also with the larger society. This may be problematic for several reasons, including pressures from both within their ethnic group and from the mainstream culture. Discrimination against immigrant individuals and groups is a common feature of intercultural relations. While objective assessments are possible, it is how people perceive their differential treatment that is thought to be psychologically important to the quality of intercultural life. These findings have implications for social work practice. Social workers need to recognize intra-ethnic differences in socio-cultural and psychological adaptation among minority ethnic adolescents and the implications for working with young people.

### **Psychological Implications of British Pakistani Muslim MSM**

Mitha, K. Edinburgh Migration, Ethnicity, and Health Research Group (EMEHRG)/Alwaleed Centre for the Study of Islam in the Contemporary World, University of Edinburgh

**Objective:** Rates of mental illness amongst LGBT are often higher than the general population. Extant work on Muslims with same-sex attraction (SSA) suggest there exists psychological dissonance between their religious identity and sexual behaviour. This presents potentiality for psychological morbidity due to issues of fractured identity, internalised homophobia, and fear of real and perceived threats to identity and selfhood. This study examines psychological processes involved in the experiences of Muslim MSM. **Methods:** Respondents were recruited via purposive and snowball sampling. A total of 25 Pakistani MSM were obtained from London and Scotland for qualitative interviews. Data were examined through the lens of interpretive phenomenological analysis to examine their experiences and internalisation of their same-sex behaviour (SSB). **Results:** Elements of fear and paranoia were evident through the multiple layers respondents spoke of regarding hiding their SSA. Elements of self-hatred were evident through respondents both vilifying themselves for their actions but also feeling vilified by the “gay scene” due to their ethnic heritage. Respondents spoke of trying to “mask” their background by claiming allegiance to an alternate ethnic group. Psychological implications were clearly evident with respondents feeling trapped, “no way out”, expressing self-hatred with elements of addictive behaviours alluded to. **Discussion:** Results indicated Pakistani MSM engage in a variety of coping techniques to dissociate their religious affiliation with their SSB. The high acknowledgement of paranoia and addictive behaviours evident are suggestive of underlying psychological symptoms, yet the reluctance to self-identify as gay, in addition to extant taboos regarding mental health, may hinder effective psychological interventions.

## OP9

### Exposure to war trauma and mental health problems among Syrian refugee children in turkey

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**Background and objectives:** The world is currently facing a humanitarian crisis since the Syrian Civil War started in 2011, resulting in a huge refugee population with unmet needs. As established in the literature, refugee children are at increased risk of developing a range of mental health problems. In this study, thus, it was aimed to examine the effect of organised violence on Syrian refugee children’s mental health. **Methods:** A cross-sectional study with 322 Syrian refugee children aged between 8 and 18 years was conducted in Turkey. Related questionnaires were used to investigate exposure to traumatic events exposed, post-traumatic stress disorder (PTSD) and emotional/behavioural problems. **Results:** Results revealed that 97.5% of children had experienced at least one traumatic event. Besides, 90.7% had been exposed to war/armed conflict in Syria, more than half (58%) had experienced life-threatening event, whereas 51.9% had lost beloved ones. 52.5% of young refugees, furthermore, were rated as above the cut-off scores for likely PTSD; whereas nearly one in three children fell under the “slightly raised” (15.7%) and “high/very high” (13.4%) scores for total emotional and behavioural difficulties. **Conclusions:** Since Europe is currently facing an unprecedented refugee crisis, establishing the mental health needs among Syrian refugee children is essential in planning appropriate interventions and services. Furthermore, as established in the literature, post-migratory difficulties such as adaptation to a different culture and language or being exposed to discrimination in the host country may increase the risk of having mental health problems among young refugees.

### Stigma, mental health and child-centred services: research with vulnerable groups

O'Reilly M, University of Leicester ([mjo14@le.ac.uk](mailto:mjo14@le.ac.uk))

**Background and objectives:** Unaccompanied refugee minors are a clinically significant group who often enter the UK with physical and mental health needs. It is well-known that globally there is unmet mental health need in many groups, but this particular group face particular challenges. While there are many barriers faced by this vulnerable group of young people, a relevant issue is stigma, culturally compounded by a range of beliefs about the very notion of mental illness. Thus, the objective of this paper is to examine these young people’s perceptions of mental illness to examine how stigma may be a particular difficulty for this group. This however, is not specific to just this cultural group and it is contrasted with research conducted with another vulnerable group, children who are homeless in Britain. **Methods:** Both groups participated in semi-structured interviews which explored their views of mental health and the potential stigma associated with it. **Results:** Results showed that the British homeless children did view the notion of mental illness in a particularly negative way, but unaccompanied refugee minors made reference to the cultural and spiritual beliefs that drove their views. Both groups of young people reflected the general stigma around mental health and access to services. **Conclusions:** Stigma is a problem and contributes to unmet mental health need. Although there have been steps taken in reducing stigma, for young people entering Britain who are unaccompanied and the previous traumatic experiences encountered, this is a particular challenge for CAHMS who need to deliver child-centred interventions to these culturally diverse groups.



## **Barriers for unaccompanied refugee minors in accessing mental health care: is it the therapy or the therapist?**

Majumder P, University of Nottingham & Nottinghamshire Healthcare NHS Foundation Trust, Nottingham, UK ([pallab.majumder@nottshc.nhs.uk](mailto:pallab.majumder@nottshc.nhs.uk))

**Background and objectives:** Even though refugee children, particularly unaccompanied refugee minors, present with disproportionately high prevalence of emotional and psychological morbidities, this group of vulnerable but marginalised young people's access to utilize mental health service has been consistently shown to be significantly poorer than the general population. However, so far there hasn't been much research to explore the possible underlying reasons or barriers for these young people to access mental health service in their host countries. This research aims to understand unaccompanied refugee minors' barriers to access and utilize specialist mental health services. We also wanted to explore any potential characteristics in the service provision that can be linked with the observed poor treatment engagement and service access. **Methods:** The study was conducted by using semi-structured interviews with fifteen unaccompanied refugee young persons and their carers to elicit their views, perceptions and beliefs based on their experience of receiving treatment from a specialist mental health service in the UK. **Results:** Thematic analysis was used to analyse the interview transcripts. After analysing the interview data, main findings were categorised into two broad themes, the participants' perceptions of the intervention received, and the professionals involved. The different elements and pertinent issues within these two broad areas were discussed. **Conclusions:** The findings will help stimulate further exploratory research into gaining better understanding of the barriers for these young people to access help, and contribute in developing services that are more efficient in engaging this vulnerable group and suitable to meet their specific needs.

## **OP10**

### **Making a change: co-creating culturally sensitive mental health services for the future, the story so far**

Glashen, J; Belfon, D, Wright, S, Palmer Hill S, Northamptonshire Healthcare NHS Foundation Trust (NHFT), Northampton, UK ([sue.palmer-hill@nhft.nhs.uk](mailto:sue.palmer-hill@nhft.nhs.uk))

**Objectives:** Health equality and improved experiences for Black and Minority Ethnic (BME) communities using mental health services is a challenge for NHS organisations. In 2015 NHFT responded to an opportunity to participate in a 'Reverse Commissioning' pilot study. The pilot aimed to support NHS organisations to engage with local BME service users/communities group in service development initiatives, thus ensuring services reflect local need. **Method:** On project initiation NHFT analysed service users' ethnicity profile data for mental health services over the preceding 3 years. Data was refreshed at 1 year and compared. Simultaneously two groups, one BME service users/community group members, the other healthcare professionals, were recruited and trained independently using the Reverse Commissioning Training Model; they were then brought together as one facilitated focus group. **Results:** Initial data analysis confirmed disproportionate levels of BME service users in 6 service areas; the data refresh demonstrated 5 areas still with disproportionate service use. It was agreed that specific and targeted input from BME reverse commissioning focus group members could explore and address these discrepancy. This group, with the support of the trust's executive, are now co-creating action plans specifically targeting areas identified and of concern to BME Communities. **Conclusions:** Northamptonshire, led by NHFT, has taken positive action to address health inequalities and user experiences of mental health services for BME communities through an innovative new approach. The project continues to evolve. Phase two 'Making a Difference' will be evaluated through an action research model to demonstrate its impact.

### **The OREMI model: delivering an African and Caribbean centred recovery day service in west London**

Phillips M, Hestia Integrated Mental Health Services, London ([malcolm.phillips@hestia.org](mailto:malcolm.phillips@hestia.org))

The Oremi Service is a targeted African and Caribbean Service in North Kensington. It supports a caseload around 200 African, Caribbean and Arabic speaking mental health service users defined as suffering severe and enduring mental ill health. The service is designed to provide support at all stages of a client's recovery journey from community engagement to Hospital and back to community and a life away from services. The presentation will detail the seven areas of intervention and the specific African Centred approach with casework illustrations and an outline of the outcome measures used to evaluate the service efficacy.

## Towards a Diversified Evidence Base for Global Mental Health: Cultural Adaptation of Community Mental Health Interventions in Pune, India

Jain S, University of Edinburgh, UK ([sumeet.jain@ed.ac.uk](mailto:sumeet.jain@ed.ac.uk))

**Objectives:** The emphasis within global mental health (GMH) on evidence-based 'packages of care' potentially supplants local innovations and capacities. This research examined the processes through which the Seher community mental health programme (Pune, India) has innovated to adapt interventions to the cultural context of low-income communities. **Methods:** Data sources include secondary programme data, interviews with staff and community mental health workers, and ethnography examining programme activities. **Results:** Between 2004 and 2014, the programme shifted orientation from mental health services to building the capacities of communities to address mental health. The cultural adaptation of interventions was premised on shifts in programme design and organizational culture. Programme design encompassed cultural ways of expressing psychosocial distress and illness and enabled support for a range of differentiated roles including mental health experts, formal grassroots workers and community volunteers, reducing dependence on 'experts'. Organizational culture was re-oriented to allow changes in programme content based on feedback from grassroots workers and communities. **Conclusion:** A more inclusive GMH 'evidence-base' must consider how programmes adapt interventions to local context. The Seher experiences suggest the importance of a dialogical flow of knowledge, competencies and skills between 'communities' and 'experts' as central to building a culturally inclusive GMH evidence base.

### OP11

#### Raising awareness about vascular dementia in the African-Caribbean community in the London

Truswell D, Independent Researcher and Consultant, London ([davidtruswell@icloud.com](mailto:davidtruswell@icloud.com))

There are an estimated 25,000 people from Black, Asian and minority ethnic communities in England and Wales living with dementia and this is projected to rise to 50,000 by 2026. Due to the migration history of the communities into the UK a large proportion of these are in the Irish, African-Caribbean and Indian population<sup>1</sup>. Service planning for dementia often does not consider the impact of dementia on Black, Asian and minority ethnic communities as when aggregate census based data when is taken as a whole minority ethnic communities are 'younger' than the white UK population. Typically first generation migrants are of young adult working age so those surviving migrants arriving in the UK in the late 1960's and 1970's now as a cohort have a high age-related risk of dementia. Research studies on the impact of dementia on the African Caribbean communities are sparse with few of the studies involving more than a handful of subjects. As well as stigma, lack of understanding of the illness and lack of knowledge about appropriate services often means that the person living with dementia does not have contact with services until there is a crisis. There is some evidence that the incidence of vascular dementia is increased in the African-Caribbean and due to the higher incidence of cardio-vascular and diabetes in these populations and the associated risks of stroke with vascular dementia as a sequel to the stroke. There is also some evidence that there is increased risk of early onset dementia in the African-Caribbean population and early onset dementias are usually vascular dementia. London, the UK capital is home to 58% of all those who identified themselves as African-Caribbean in the UK 2011 National Census. For African-Caribbean men under the age of 65 strong cultural beliefs lead some of those most at risk to dismiss any mainstream efforts at health education about dementia. Culture Dementia UK a voluntary organisation has been working on awareness raising and providing support in the African-Caribbean community in London since 1998. The presentation explores how African-Caribbean personal narratives of independence and resilience that have supported people through migration can be a barrier to help-seeking in dementia.

#### Engaging BME Communities in Psychological Therapies through Community Development

Emilion J, Cognitive Analytic Psychotherapist, London ([jessie.emilion@virgin.net](mailto:jessie.emilion@virgin.net))

Culture, race, language and religion play a key part in the development of self, personality and identity. Engagement or disengagement with mainstream mental health services are in turn highly influenced by these factors. The paper will specifically discuss issues of racism, bi-lingualism and cross cultural issues, and focus on how some minority communities in London in London were engaged through Intercultural and linguistically appropriate psychological interventions within the community. Race and racism often create a sense of alienation and exclusion in individuals and in minority communities. The minority communities we worked with

had developed their own mechanisms to protect against alienation, by mutual exclusion and withdrawal from statutory services, leaving individuals within these communities isolated. Language, as central to communication also plays a crucial part in the expression of distress, and but also in the integration, positioning and acculturation of the individual in society. For many people not being able to speak the language of the host culture compounds the sense of alienation, loss and displacement. Religion in its varied roles, is another key element in BME communities. Naming and understanding the stigma around mental ill health, exploring the role of third sector organisations and understanding power dynamics between statutory and third sector organisation has been central to our work with BME groups. The paper discusses our experiences, including the development of the 'community engagement model' (Mwasambili 2011). In IAPT this was used to effectively engage minority ethnic groups and work in partnership with third sector organisations to promote access to psychological therapies.

### **Cognitive tests to detect dementia in people from British minority ethnic background: Are we there yet?**

Velayudhan L, Oxleas NHS Foundation Trust, Surrey, UK

The number of elderly is set to rise in coming decades and the prevalence of dementia will double in the UK by 2050. It is increasingly important for efficient early diagnosis of those with suspected dementia and requires quick, meaningful cognitive tests in both primary and secondary care setting. Routinely used cognitive tests underestimates the abilities of older people in British minority ethnic (BME) groups leading to either risk of misdiagnosis or a lack of diagnosis of dementia. Factors such as differences in extent of formal education, lack of familiarity with English, lack of literacy in own first language, and culture-specific factors related to individual test items are some of the reasons. Attempts have been made to adapt existing tests, adjustment of cut-off-points, translation and replacement of culture-specific items; however, these measures have not improved the accuracy universally. Mini Mental State Examination in translated versions is the most commonly used cognitive test for BME groups but it has limitations. Tests such as Mini-Cog, 7-minute screen test, Time and Change Test, Rowland Universal Dementia Scale, Montreal Cognitive Assessment and Hopkins Verbal Learning Test have shown promising results, but they require further evaluation.

## **Workshops**

### **WS3**

#### **Psychiatry, racism and human rights; the limitations of the western illness model.**

Fernando S (Honorary Professor, Faculty of Social Sciences and Humanities, London Metropolitan University)  
Kalathil J (Independent researcher, Survivor Research) and Thomas P

**Rationale:** A critical transcultural approach to mental health shows that *what is 'illness' and 'health' in the 'mental' field are always culturally and socially determined*. A *human rights* approach argues that persons receive help for problems that are called 'mental health problems' in ways that respect their autonomy, identity, agency and self-determination. It means that mental health services need to be consistent with their personal, political and socio-cultural backgrounds, are locally relevant and free of racism. Participants are invited to watch a documentary film - the real-life story of a black man who was sectioned and forced to have medication in order to discuss interactively questions on the limitations of the western medical model, especially when applied in multicultural settings and in culturally non-western populations; and the extent to which racism may distort the way professionals make decisions about diagnoses and sectioning (compulsory treatment) in a country such as the UK.

#### **Agenda:**

- (a) 20 minute interactive session discussing race and culture issues generally.
- (b) 50 minute film screening of film "Whose Mind is it Anyway; the Story of John"
- (c) 20 minute interactive discussion

## WS4

### Peer-supported Open Dialogue (POD) and the related new Dialogue First service

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POD is a UK variant of the Open Dialogue approach as currently practised in Finland and trialled in several countries around the world. Its core principle involves the provision of care at the social network level, by staff that has been trained in family, systems and related approaches. The 'open' refers to the transparency of decision-making - network meetings being the only forum where the client is discussed. The 'dialogue' is the therapeutic conversation that takes place within meetings. Two key therapeutic principles are *tolerance of uncertainty* and *polyphony* (multiple viewpoints). The emphasis in POD is on 'being with', rather than 'doing to'. All participants embark upon a journey together; mutual transformation and acceptance are core values. In meetings, the therapists aim to foster a dialogue in which everyone's voice is heard and respected. The process enables a new sense of self and associated levels of functioning and capability to develop. OD outcomes far exceed those for usual treatment in the developed world, despite low use of antipsychotics. Staff from four UK National Health Service (NHS) organisations have completed the first wave of training in Peer-supported Open Dialogue and have formed POD teams in their respective trusts. These teams have started seeing families using the POD approach, and will be involved in a planned multicentre randomised control trial. An addition development is the new *Dialogue First* service in North East London, a non-crisis community mental health service operating along open dialogue principles, and open to GP referrals from anywhere in the UK. In terms of the workshop, a summary of background information on POD will be followed by a role play to introduce the dialogical process to the audience, and to encourage discussion. This in turn, will be followed by a presentation on *Dialogue First*, after which there will be time for questions and discussion.

# ABSTRACTS

## POSTER PRESENTATIONS

### POS1

#### **Establishing a mental health and psychosocial support (MHPSS) service within a medical hospital in Sierra Leone following Ebola disease outbreak**

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**Background:** Ebola Virus Disease (EVD) worsened the fragile healthcare system in Sierra Leone. King's Sierra Leone Partnership (KSLP) were asked to support the Government's response to provide services for people with mental health and psychosocial problems. **Objective:** To establish a nurse-led MHPSS service integrated into the acute medical hospital, providing inpatient and outpatient care. **Methods:** The service accepts referrals for individuals of any age with known or suspected mental health problems. Fees and charges are waived for those unable to pay. Other activities include support sessions (group and one-to-one) for EVD healthcare workers; mental health awareness training for general nurses; and outreach sessions to community hospitals. **Results:** over 12 months: Of the 140 patients seen: 52% (n=75) of them female; 19% (n=27) were children <17yrs; 55% were inpatients; 5% were EVD survivors; and 9% had been affected by EVD. Disorders included: psychosis (21%, n=30), moderate-severe depression/emotional distress (12%, n=17), epilepsy/seizures (7%, n=10) and 'other psychological complaints' (50%, n=71) which included mild emotional distress/ depression, mild anxiety disorders, grief and social problems. Management included psychological interventions (61%, n=141); medication (14.6% n=34); and social interventions (25%, n=58). **Conclusions:** A successful partnership between the Health Ministry, KSLP and the hospital management enabled the building of a stronger mental health service (increasing access to treatment and providing psychosocial support to Ebola healthcare workers during the outbreak) and replicating this throughout the country. Lack of affordable psychotropic medications, limited service user involvement and a need for a multidisciplinary approach to care remain challenges.

### POS2

#### **Exploring barriers to help seeking for eating disorders among south Asian people in Leicester: a qualitative study**

Wales J, Brewin N, Leicester Partnership NHS Trust; Raghavan R, De Montfort University; and Arcelus J, University of Loughborough ([jackie.wales@leicspart.nhs.uk](mailto:jackie.wales@leicspart.nhs.uk))

**Objectives:** Referrals to specialist eating disorder services from the South Asian community are under-represented, despite research suggesting that disordered eating attitudes and behaviours of South Asian people are similar to the population in general. The study aimed to identify potential barriers to help seeking and sought to inform the development of posters/leaflets to encourage people to consult their GP if experiencing eating difficulties. **Method:** A qualitative study was conducted in Leicester. Focus groups were conducted with members of the South Asian community (n=6, participants n=28). A key informant focus group was conducted with clinicians working within the local specialist eating disorder service (participants n=14).

**Results:** A number of factors appear to act as barriers to help-seeking for eating disorders. For some there was a reluctance to seek help for mental health issues generally, with people being concerned regarding potential stigma and shame. People were much more likely to seek help for physical rather than psychological problems. Low awareness of eating disorders, particularly amongst older Asians, was also a key barrier. There was low appreciation of the potential seriousness of eating disorders. Ideals regarding body shape and family living circumstances may delay help-seeking. **Conclusions:** Improved education around eating disorders may encourage help seeking. Posters and leaflets, in isolation, will have limited utility in supporting this. Interventions designed to reduce stigma around mental health issues in general and encourage early help seeking would be advantageous.

## POS 3

### **Assessment and management of needs of children of people with young onset dementia within Younger Persons Memory Service, MHSOP, LPT**

Harvey Z, Yong E, Velayudhan L, Leicestershire Partnership NHS Trust, University of Leicester (zenabayatti@yahoo.co.uk)

**Background and Objectives:** Young onset dementia (YOD) is defined as onset of symptoms of dementia before the age of 65 years. People under 65 years are likely to still be working, and they may be carers for under-age children, so the disease affects both economy and family life in a different way than in older patients. There is limited work on needs of children of people with YOD as there are not many dedicated service for them. Nicholas et al (2013) did focus groups in 14 young carers aged 11-18 showed overlapping theme areas: emotional impact of living with a parent with dementia, caregiving, coping, symptoms, diagnosis, relationships, and support, identifying opportunities for professionals to assist them. Our objectives were to conduct a clinical audit to find if clinicians working in YOD service were screening for care needs and issues around children living or cared by parents/people with YOD, and also to find the steps undertaken as management measures. **Methods:** This is a retrospective study for all consecutive patients seen within the Younger Persons Memory Service during the period from 1<sup>st</sup> June 2014 to 30<sup>th</sup> November 2014 (n= 288) Following approval of the project proposal and data tool by the Community Health Service Audit Group/Committee, we are reviewing the case notes and electronic patient records for the following information: (1) Does every clinician at initial and subsequent contact checks and documents if patient cares or lives with any children and also document child's age, gender, relationship? (2) Is there a quick response from other services to prevent psychological and development damage to children living with patients with YOD? (3) Do all the clinicians involved have appropriate training/experience such as level 3 safeguarding for children? (4) Were the interventions provided prompt and appropriate; and (5) Were the issues reflected in the care plan? **Results and Conclusions:** We are currently in the process of collecting the data, and will present the results and findings following analysis at the Conference.

## POS 4

### **Experiential Learning from Developing A Positive Support Short Message Service (SMS) for Improved Mental Health at the Community Level**

Pasha, A. Hasnain, Z. Qazi, T. Qureshi, O. Khan, A. Interactive Research and Development, Karachi, Pakistan ([zafar.hasnain@irdresearch.org](mailto:zafar.hasnain@irdresearch.org))

**Objective:** According to the Pakistan Telecommunications Authority report (2014), 73% of the population uses cell phones, showing great potential for mHealth expansion in the country. Interactive Research & Development (IRD) has developed a positive support SMS service that consists of supportive messages on mental health. A pilot conducted by IRD revealed that 84% of the sample was receptive to this service. IRD aims to provide this service to increase mental health support access and complement psychosocial therapy that is being conducted on people suffering from depression and anxiety. **Methods:** A list of 45 messages were developed and are dispersed once daily to subscribers. Consent and phone numbers are collected through an existing mHealth application that asks individuals being screened for depression and anxiety whether they want to enrol in the SMS service. Subscribers can reach out to IRD via a provided helpline number to obtain more information about the program and its activities. **Results:** The SMS component is currently reaching more than 10,000 subscribers and elicits an average of 2-3 calls and/or SMS a day. Approximately 73% of these responders reached out seeking advice on mental distress and 12% ask for appointment scheduling. **Conclusion:** There are many beneficial implications to such a trial, including the increased access of mental health interventions to remote populations. Programs considering this service can glean the learning of this service in their design phase. IRD is currently working on piloting an interactive SMS system to provide and promote care-seeking tendencies.



## POS 5

### The milestone study: improving transition from child to adult mental health services in Europe

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**Objectives:** The main objectives of the MILESTONE study are to determine a) long-term health and social outcomes of young people who cross the transition boundary of their child and adolescent mental health service (CAMHS); and b) the effectiveness and cost-effectiveness of a model of Managed Transition (MT) in improving these outcomes. MT includes feedback to clinicians from a Transition Readiness and Appropriateness Measure (TRAM). **Methods:** The study is being conducted in eight European countries. It involves the identification of over 1000 young people approaching the CAMHS-AMHS transition boundary and implementing MT in a randomly selected subset. Fifty-two CAMHS clusters have been randomly allocated to the intervention or control group using a two-stage process (approx. 1:3 ratio). Young service users aged 15 to 18 years reaching their service specific TB during a 12 month recruitment period are eligible for inclusion and contribute data, together with parents/carers and clinicians, at baseline, 9, 18, and up to 27 months. **Results:** Recruitment is due to complete in September 2016, last follow-up assessment occurring in 2018. The study will provide unprecedented information about the quality of transition and transition experiences in different European countries in relation to young people's long term mental health, social and functional outcomes, and the effectiveness of MT in improving transitions and these outcomes. **Conclusions:** Findings from the study will help transform mental health care in the EU for young people, enhance patient outcomes, quality of life, and service satisfaction, and improve mental health status at individual and population levels.

## POS 6

### Community, Identity & Mental Health: Lessons from Basic Needs Interventions in Ghana & Karnataka, India

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**Objectives:** To analyse the design and implementation of the BasicNeeds Model for Mental Health and Development and its applicability across cultural spaces. Research will pose the following central questions: To what extent are notions of mental health necessary to framing of development as freedom? Through what mechanisms may participants become agents of their own change, as well as that of their communities and health systems? **Methods:** The author shall conduct a comparative analysis of BasicNeeds and partner operations across sites in Ghana and Karnataka, India. Qualitative methods employed shall include: Semi-Structured Interviews with BasicNeeds Staff, Governmental and Medical Professionals; Life-Story and Narrative Data Collection of Mental Health Intervention Participants; and Participatory Data Analysis. **Results:** The BasicNeeds Model, in practice, can be seen to be geared to the interrelationship of the creation of demand for and facilitation of supply of accessible, affordable and equitable quality mental health services. Expressions of demand by participants were heavily linked to breadth of Mental Health Literacy. This often lead to an emphasis on medical interventions as the primary and immediate identified need of users, creating a linear narrative of stabilisation and the ordering of medical, economic and social concerns. **Conclusions:** A developmental approach to mental health interventions, with a focus upon participation, empowerment and broadening capabilities places emphasis upon the subjectivity and agency of Persons with Mental Illness and Epilepsy (PWMIE). Such interventions, however, must take care to highlight the relationship between Western biomedical and culturally diverse constructions of mental health and illness which come frame the parameters of knowledge and inform notions of self-hood and the perception of needs.

## POS 7

### Faith-based care: Perspectives of Muslim religious leaders/imams and clinicians

Mitha, K. Edinburgh Migration, Ethnicity, and Health Research Group (EMEHRG)/Alwaleed Centre for the Study of Islam in the Contemporary World, University of Edinburgh ([k.mitha@sms.ed.ac.uk](mailto:k.mitha@sms.ed.ac.uk))

**Objectives:** The role of religion in psychiatry is often controversial. For Muslim patients, this takes on greater significance given many would prefer to have religious-based guidance incorporated into their holistic treatment, yet there may be reticence to engage in this in clinical practice. This study considers the



perspectives of Muslim religious leaders/imams and Muslim clinicians regarding their views on religious frameworks on mental illness and the relationship regarding religion and psychiatry/psychology. **Methods:** Participants were Muslim clinicians and mental health workers (n= 10) as well as religious leaders/imams (n = 10) and were obtained through both purposive and snowball sampling through NHS trusts and religious centres in Scotland and London. Qualitative data was analysed via thematic analysis. **Results:** As hypothesized, there was a differential in religious discourse in explanatory models of mental illness, with religious leaders/imams using faith-related explanations for experiences of mental distress. None of the religious leaders/imams spoke of factors such as djinn, instead attributing mental illness to issues with *iman* (faith), viewing “faith healers” as charlatans taking prey on the gullible and disadvantaged. Whilst Muslim clinicians viewed religion as playing a role in psychiatry, viewing it as complementary and playing a protective role for patients, religious leaders/imams felt psychiatry/psychology was limited in its reach and a spiritual dimension would have added benefit. **Conclusion:** This study shows that both Muslim clinicians and religious leaders/imams saw religion as playing a role in mental illness. Clinicians appeared to take a lead from patients regarding utilising religious-based discourse. The views of religious leaders/imams suggest there could be greater collaboration amongst clinicians to acknowledge patients’ spiritual needs in holistic care.

## POS 8

### Antenatal depression and anxiety in pregnant women, Karachi, Pakistan

Pasha, A. Qureshi, O. Saleem, S. Khan, A. Interactive Research and Development, Karachi, Pakistan  
([onaiza.qureshi@irdresearch.org](mailto:onaiza.qureshi@irdresearch.org))

**Objective:** The WHO reports that 10% of women experience mental distress during pregnancy. The prevalence of antenatal depression is reported as 7.4 % in the 1st, 12.8 % in the 2nd & 12.0 % in the 3rd Trimester (Bennett, Einarson, Taddio, Koren, & Einarson, 2004). Despite higher reported prevalence, screening for antenatal depression and anxiety is not commonly practiced in Pakistan. This issue stresses the need for research into antenatal depression as a public health issue. Our aim was to assess the prevalence of antenatal depression and anxiety during pregnancy and associated risk factors to improve services for maternal health in a holistic manner. **Methods:** A total of 1,070 women were screened between December 2014 – Feb 2015 for depression and anxiety at a public sector hospital in Karachi. A dedicated worker screened women seeking antenatal care, with oral consent for depression and anxiety using a standardized Urdu version of the SRQ-10. **Results:** Data analysis revealed that 23% of sample population reported symptoms of depression and anxiety consistently over 2 weeks. IRD is currently in the process of obtaining trimester stages and risk levels for these patients from the public hospital. **Conclusion:** The results indicate a need for systematic screening for symptoms of depression in women seeking care at antenatal clinics. The results of this study will benefit our assessment of maternal mental health care services by identifying groups which are susceptible to depression and anxiety during pregnancy and hence requiring greater attention in terms of diagnosis, treatment and counselling.

## POS 9

### Experiential learning from the development and roll-out of a mhealth application for mental health

Hasnain, Z. Pasha, A. Qureshi, O. Khan, A. Interactive Research and Development, Karachi, Pakistan  
([zafar.hasnain@irdresearch.org](mailto:zafar.hasnain@irdresearch.org))

**Objective:** In 2014 Interactive Research and Development was awarded a Grand Challenges Canada grant to develop and implement a community-based mental health program using mobile phone based screening tools to screen for depression and anxiety. IRD aimed to follow an integrated innovation system for the development and use of an mHealth application for mass screening of depression and anxiety. The goal was to make fast action and decision making possible based on treatment progress and outcomes by eliminating paper forms and making data collection more efficient. **Methods:** A codebook was designed based on a time driven action based algorithm for screening. A two-tiered screening process, treatment updates, GPS tracking, demographics and personal contact details were integrated into the app to monitor clients. A number of application revisions have been generated to deal with server issues and application bugs, leading to the development of an offline saving for uploading forms at a later date and time. **Results:** From February, 2015 till present, a total of 40,643 people have been screened using the app. The application has generated comprehensive data on the scores of depression and anxiety, treatment updates, GPS coordinates

for these people. **Conclusion:** The mental health mHealth application has been observed to be a successful and effective method for mass screening and assessing the general prevalence of depression and anxiety. Future implications of the mHealth application can be to integrate more holistically within primary and public healthcare facilities to improve diagnosis, treatment adherence and outcomes.

## POS 10

### **Exploratory RCT of a group psychological Intervention for Postnatal Depression in British Mothers of South Asian Origin – ROSHNI-D**

Nusrat Husain, Karina Lovell, Farah Lunat, Najia Atif, Asad Bhokari, Issak Bhojani, Barbara Tomenson, Waqas Waheed, Atif Rahman. Nasim Chaudhry

**Introduction:** Postnatal depression (PND) is a major public health concern because of its impact on the mother, infant and the family. Higher rates of postnatal depression in South Asian women living in the high income countries suggest ethnicity to be a significant risk factor for developing PND. PND is a treatable disorder, antidepressants are effective, but new mothers may be reluctant to take such medications. Cognitive Behavioural Therapy (CBT) is recommended by the National Institute for Health & Clinical Excellence (NICE) as a first-line treatment for PND. Such treatments need to be culturally adapted to meet the needs of minority communities, who are often excluded because of gender or language and cultural differences. **Objectives:** To conduct an exploratory trial to test the feasibility and acceptability of a culturally adapted group Cognitive Behavioural Therapy (CBT) intervention (Positive Health Programme (PHP) with British South Asian women. **Aim:** We aimed to determine if depressed BSA women receiving the PHP intervention will show significant improvements in terms of severity of depression, marital support, and social support as compared to the control group. **Methods:** We used a two-arm pragmatic single-blind randomised controlled design. Women meeting the inclusion criteria were randomised either to the experimental group receiving PHP or treatment as usual (TAU) that is standard care usually provided by the GP. **Results:** A total of 615 mothers were screened for participation in the trial, of these 137 were assessed further to determine eligibility. 83 mothers were randomized to receive either PHP (n=42) or treatment as usual (TAU) (n=41). Overall the mean number of sessions attended was 6.6, SD= 5.2, range 0 to 12 sessions. Spearman's correlation coefficient between the number of sessions attended and reduction in HRSD score from baseline to follow up 1 was 0.35,  $p=0.048$ , with greater reductions in HRSD score being associated with more sessions attended. Mothers found the intervention to be acceptable and felt an overall positive change in their attitudes, behaviour and confidence level. **Conclusion:** The recruitment and retention figures (70%) highlight the ability of the research team to engage with the population. The findings suggest the acceptability of the culturally adapted PHP intervention for British South Asian women with postnatal depression.

## POS 11

### **Exploratory RCT of a group psychological intervention for Postnatal Depression in British Mothers of South Asian Origin - Post intervention Qualitative Study**

Yumna Masood, Karina Lovell, Farah Lunat, Najia Atif, Waqas Waheed, Atif Rahman, Rahena Mossabir, Nasim Chaudhry and Nusrat Husain.

**Objective/Background:** Postnatal depression affects 10-15% of all mothers in Western societies and remains a major public health concern for women from diverse cultures. British South Asian women have a higher prevalence of depression in comparison to their white counterparts. Research has shown that culturally adapted interventions including Cognitive Behavioural Therapy (CBT) may be acceptable and help to address the needs of this population. The aim of the study was to explore the acceptability of the group Positive Health Programme (PHP) based on the principles of CBT and to understand the overall experience of the British South Asian women receiving the Positive Health Programme intervention. **Methods:** This was a nested qualitative study as part of an exploratory RCT to test the feasibility and acceptability of a culturally adapted intervention (Positive Health Programme (PHP)). Qualitative methods were used to determine the views of the participants on the feasibility and acceptability of the PHP intervention. Ethical approval was granted from the National Research Ethics Service reference number: REC10/H1005/62 **Results:** A total of seventeen semi-structured interviews were completed and thematic analysis was carried out to identify and report themes emerging from the data set. The participants found the intervention acceptable and felt an overall positive change in their attitudes, behaviour and confidence level. **Discussion/Conclusion:** The findings suggest the acceptability of the PHP intervention to British South Asian women. The reason for this positive change was attributed by the participants to the combination of the facilitator's role and the

acquisition of coping strategies acquired over the period of 12 weeks sessions. Furthermore, this was reflected in an overall positive change in dealing with family members and their own children. These results support that culturally sensitive interventions can lead to better health outcomes and overall satisfaction. This is one of the very few studies looking at the overall process of development and implementation of culturally specific psychological interventions for the British South Asian community.

## POS 12

### **Multi Centre RCT of a group psychOlogical intervention for poStnatal depression in britishH mothers of south asiaN origin - ROSHNI-2 (The word Roshni means 'light' in Urdu/Hindi) – Study protocol**

Nusrat Husain, Karina Lovell, Farah Lunat, Chris Williams, Carolyn Chew-Graham, Penny Bee, Waquas Waheed, Najia Atif, Nasim Chaudhry, Atif Rahman, Najma Siddiqi, Jill Morrison, Joe Kai, Terry Brugha, Shanaya Rathod, Chris Roberts, Ilyas Mirza, Kamaldeep Bhui, Clare Baguley, Linda Davies, Isaak Bhojani, Peter Bower, Richard Morris

**Introduction:** Postnatal depression is known to cause disability and suffering in women and negative consequences for their infants and their family with huge costs to society. Mothers from South-Asian backgrounds (Bangladesh, Pakistan and India) make up for a very large number of births in the UK and particularly in centres participating in this study. The rates of postnatal depression (PND) in British South Asian women are higher than the general population. Due to linguistic and cultural barriers, British South Asian women have less access to health care services. This has been highlighted as a major contributor to ethnic disparities in healthcare across the UK populations. **Aim:** The aim of this proposed project is to evaluate the clinical and cost effectiveness of a culturally adapted group psychological intervention (Positive Health Programme, PHP) in primary care for British South Asian (BSA) women with postnatal depression compared with treatment as usual. **Methods:** Participants will be recruited from general practices and children centres in areas of high BSA density in North West, East Midlands, Yorkshire, Glasgow and London. **Target Population:** Self-ascribed British South Asian women meeting DSM V depression criteria, aged 16 years or above, and having an infant up to 12 months of age. The primary outcome is recovery from depression (Hamilton Rating Scale for Depression (HRSD) score less than 7) at 4 months (end of intervention). Economic analysis will estimate the costs of health and social care and quality adjusted life years (QALYs) from a societal perspective. Qualitative methods will be employed to explore patient and professional experiences. **Dissemination and impact:** Results of the main trial and each of the secondary endpoints will be submitted for publication in a peer-reviewed journal. Information will be collated to provide an educational tool for community leaders, family and caregivers. This will in turn promote understanding and raise awareness of the identification and treatment of depression in general and postnatal depression in particular within the South Asian community. Impact on service users: The project will help translate the research into action. Reduction of postnatal depression, improved child and family outcomes and better quality of life, increased awareness, improved relations and higher satisfaction. There can be other wide ranging positive outcomes, including improvements in parental care and life course (e.g. greater employment)

## POS 13

### **Beliefs attitudes and perceptions of Schizophrenia among South Asian population: A review of Evidence**

Raghavan R; Griffin E, De Montfort University; Noushad F, Sriram V, Leicester Partnership NHS Trust, Leicester, UK

**Introduction:** Schizophrenia represents a major psychological health concern which can have a detrimental impact on sufferers and their families. With more than 20 million people experiencing schizophrenia world-wide, it is thought to affect approximately 1% of the population at some point throughout their lives. Whilst there has been considerable research examining the beliefs, attitudes and perceptions of schizophrenia among Western nations, these areas have received considerably less attention among the South Asian population. South Asian countries have very high numbers of people diagnosed with schizophrenia, but there is a dearth of research examining the perceptions and views of individuals from these countries. **Method:** Therefore, this structured scoping review was aimed to assess the current state of literature surrounding the perceptions, attitudes and beliefs of schizophrenia among individuals from South Asian origins and to produce a scientific summary of relevant evidence surrounding these areas. **Results:** This systematic scoping review examined 31 papers surrounding the perceptions, attitudes and beliefs of

schizophrenia among individuals from South Asian origins and generated a scientific summary of relevant evidence. Broadly speaking, the papers covered four key areas with a certain degree of overlap. These were stigma, cultural perceptions of mental illness, religious and spiritual beliefs, and experiences. **Conclusion:** Tackling stigma in developing countries can affect the way in which individuals seek help and have implications on the development of a national policy in countries with limited health sector resources. The key evidence generated and its implications for therapeutic practice and service delivery are discussed.

## POS 14

### Understanding the Peer Perspective: Challenges and Motivating Factors in a Peer Delivered Intervention for Maternal Depression

J Dasgupta<sup>1</sup>, P Rath<sup>1</sup>, A Lazarus<sup>2</sup>, R Shidhaye<sup>1, 1</sup> Public Health Foundation of India, India; <sup>2</sup> Sangath, India ([jayashree.dasgupta@phfi.org](mailto:jayashree.dasgupta@phfi.org))

**Objectives:** Efficacy of peer delivered interventions for maternal depression have highlighted utility of using peers as delivery agents, particularly in resource limited settings. It is important to understand motivating factors and challenges faced for effective implementation. This study looks at preliminary data on experiences of peers delivering an intervention for maternal depression at the homes of pregnant women in Goa, India. **Methods:** Mothers from the community were trained to deliver The Thinking Healthy Program for Peer Delivery (THPP), a cognitive behaviour therapy based intervention for maternal depression, as part of an ongoing randomized controlled trial on efficacy of this intervention. To identify barriers and facilitators in taking on the role of a delivery agent, focus group discussions (FGDs) were carried out with mothers and in-depth-interviews (IDIs) with their supervisors. Data from three FGDs and four IDIs were analysed using a framework approach. A coding index was developed with a priori codes based on literature review of barriers and facilitators in peer delivered interventions, and emergent themes were identified. Further IDIs and FGDs with peer delivery agents will be carried out until a saturation of themes. **Results:** Preliminary data indicates that motivating factors for the peer delivery agents were mostly internal in nature. In addition to finding the intervention meaningful, peers reported personal benefits such as increased knowledge about healthy lifestyle, self-confidence, improved interpersonal relationships and increased status within the family and society. Barriers were largely logistical including transport difficulties reaching the depressed mother's home, lack of space and privacy, and challenges scheduling sessions due to personal commitments. Other barriers included resistance from family members due to stigma and lack of financial incentives. **Conclusion:** Peer delivery agents are motivated to deliver the intervention as they see it being beneficial. However, it is important to explore how challenges they face can be addressed in a culturally sensitive manner for more effective intervention delivery.

## POS 15

### Multilingualism in inpatient mental health care in Germany

Mike Mösko, Milka Jakovljevic, Antonia Diederichs, Oriana Handtke, Demet Dingoyan, Holger Schulz ([o.handtke@uke.de](mailto:o.handtke@uke.de))

**Introduction:** Language-related barriers present on of the main barriers in access and quality of provision of outpatient mental health care services for patients with a migration background (Mösko et. al., 2013). Psychotherapists estimate that 6% of their adult outpatient patients are not proficient enough in German to undergo therapy and therefore need multilingual therapist or treatment with interpreters (Odening et al., 2013). This study aims at picturing the current state of multilingual treatment offers in inpatient mental health care services in Germany. **Method:** A quantitative questionnaire was chosen to assess the dissemination and types of multilingual treatment offered by 661 inpatient mental health care institution in Germany. The questionnaire was developed and evaluated by different experts. It was send by mail to the heads of the institutions. **Results:** The respond rate was 34.6%. 219 questionnaires (33.1%) were filled-out completely and used for data analysis. 60 (27.4%) institutions offered treatment in at least one language other than German. All together treatment was offered in 22 different languages. The most were Turkish (N=23) and Russian (N=22). 83 (37.9%) institutions sought help from external interpreter services. 46 institutions (21.4%) made use of their psychotherapist's language skills and offered multilingual treatment. 69 institutions (32.1%) didn't use their staff's existing language skills. **Conclusion:** This data shows that even though languages of the common migrant groups are often available in inpatient mental health care institutions in Germany,

multilingual treatment offers are still limited. The results must be interpreted carefully because of a restricted respond rate and a possible respond bias.

# GENERAL INFORMATION

The conference venue is Devonshire Place Conference and Event Centre, 78 London Road, Leicester LE2 0RA. The venue is close to Leicester City Centre and within easy access to Motorways and less than 2 minutes' walk from the Leicester Railway Station.

## **PARKING:**

There is limited car parking facility at the conference venue. There are a number pay and display car parks near by the conference venue.

## **REGISTRATION**

Registration desk will be open from

8.00 to 19.30 on 22 June

8.00 to 18.00 on 23 June

8.00 to 16.00 on 24 June

Registration is required for all participants. Registered participants are requested to wear their badge at all times.

## **KEYNOTE/ CONCURRENT ORAL PRESENTATIONS/ WORKSHOPS**

All Panel keynote sessions are in the Oliver Suite

All poster presentations are in the Holmes Dining Room

Oral concurrent sessions and workshops are held in Oliver Suite, Morley Dining Room, Morley Lounge, Holmes Lounge, Front Lounge, and Committee Rooms 1, 2, 3 and 4.

## **CONFERENCE RECEPTION**

All participants are invited for the conference reception on the evening of 22 June

## **CONFERENCE DINNER**

The pre-booked optional conference dinner is to be held on 23 June at 7pm at Devonshire Place

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